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FOR ACTION

THE BAMAKO INITIATIVE

Progress report

SUMMARY

The present report describes the progress made in implementing the Bamako Initiative. It discusses the contribution made by the Initiative to the provision of an accessible, affordable and sustainable health care delivery system in sub-Saharan Africa as well as in other regions of the world. A core group of 18 countries, covering about 20 million people in over 200 districts, is well under way with revitalizing basic health services with the involvement of communities in management and financing. The report analyses continuing constraints, both programmatic and operational, to implementation, especially the continuing resistance of many countries to bring about meaningful policy changes in support of the Initiative. In response to the request of the Executive Board at its 1991 session, the present report is considerably more factual than previous reports, owing to a greater effort in data collection and the establishment of monitoring systems.

As recommended by the Executive Board at its 1990 session, UNICEF has continued to channel additional general resources to several countries under full implementation of the Initiative. Some additional donor support has been received, but there continues to be an urgent need for further donor support in order to maintain the achievements made to date and to respond to the increasing financial contribution provided by communities themselves.

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INTRODUCTION

1. The Bamako Initiative has begun to demonstrate that the utilization of public sector health services increases once the quality of care has been raised sufficiently to attract community involvement in both financial and management support. Communities are going ahead decisively in many countries. National Governments, even in the face of positive achievements, continue in some instances to resist the changes in policy and resources that would effectively restructure health systems in line with needs and the demands set by the health goals of the 1990s. Where broad-based government/community/donor alliances are in place, there is a greater likelihood of effective national action in policy development and change within the framework and guidelines established by the Ministers of Health of Africa at their Regional Committee Meeting in 1988.

2. The greater availability of data has increased the specificity of analysis in reviewing the progress made in the Initiative during the past year, especially in corroborating the importance of the Initiative in providing the appropriate health infrastructure needed to address the major health problems affecting children and mothers.

I. THE BAMAKO INITIATIVE: A DISCUSSION OF ISSUES

3. At present, about 4 million children under five years of age are dying in sub-Saharan Africa every year (overall infant mortality rate (IMR) of 111 per 1,000 live births) mainly from malaria, diarrhoeal diseases and acute respiratory infections (ARI), although measles is still a major cause of death (cited in 14 of 33 countries reporting in 1991). At the same time, over 100,000 women are dying from causes involving childbirth (overall maternal mortality rate of 500 per 100,000 live births). Malnutrition, parasitic diseases and human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) are seriously complicating this mortality pattern. For mortality reduction to be effective in the years before the end of the decade and the goals of the World Summit for Children to be seriously tackled, a massive concentration of effort is required to attack the diseases affecting children and women in Africa. This necessarily means focusing on (a) the prevention and treatment of malaria, diarrhoeal diseases and ARI; (b) sustaining immunization coverage; (c) safe motherhood practices; and (d) vigorously promoting AIDS prevention.

4. For this African children and women's health agenda, the summoning of improved technical know-how, the raising of public awareness and political mobilization are key strategies being pursued. Concrete action is not possible, however, without a basic health care delivery system, and this is the weakest aspect of the African health situation. At present, almost half of the continent has no access to basic care. In the 2,700 districts of sub-Saharan Africa, there are only 10,000 public sector health centres or dispensaries, staffed in many places by only one or two nurses and catering on

Table 1

RANKING OF CAUSES OF UNDER-FIVE MORTALITY IN 33 COUNTRIES

Disease	First	Second	Third	Fourth	Fifth
Anaemia	0	0	0	4	4
ARI	7	11	10	1	2
Diarrhoea	3	14	12	3	0
Malaria	17	4	4	3	2
Malnutrition	1	1	5	4	8
Measles	1	2	1	7	3
Meningitis	0	0	0	2	1
Tetanus	0	0	1	0	2
Typhoid	0	0	0	0	1

Source: UNICEF country office data.

Table 2

HEALTH OVERVIEW OF SUB-SAHARAN AFRICA

Total population*	443,644,000		
Number of annual births*	27,277,300		
Overall IMR (Continental Africa + Madagascar)*	111	(range 173 to 61 per 1,000 live births)	
Estimated total number of under-five deaths*	4,004,579		
Estimated total annual number of maternal deaths	127,128		
Overall access to health services*	56%		
Total expenditures (health)	$641,389,000	(19 countries)	
Government health expenditures (per capita)	$1.45	(19 countries)	
Number of districts (41 countries)	2,661		
Number of district hospitals	3,784	Public 2,504	Private 1,280
Number of health centres/clinics	11,416	9,955	1,461
Number of health posts	27,680	26,109	1,571
Ratio of health facility to people	1:10,346		
Number of doctors	38,754	Public 34,256	Private 4,498
Number of nurses	215,876	188,432	27,444
Number of midwives	77,314	77,314	
Number of other health workers	156,394	156,394	
Ratio of health professionals to people	1:1,337		

Source: UNICEF 1992 State of the World's Children* (43 countries).
UNICEF country office data (37 countries).

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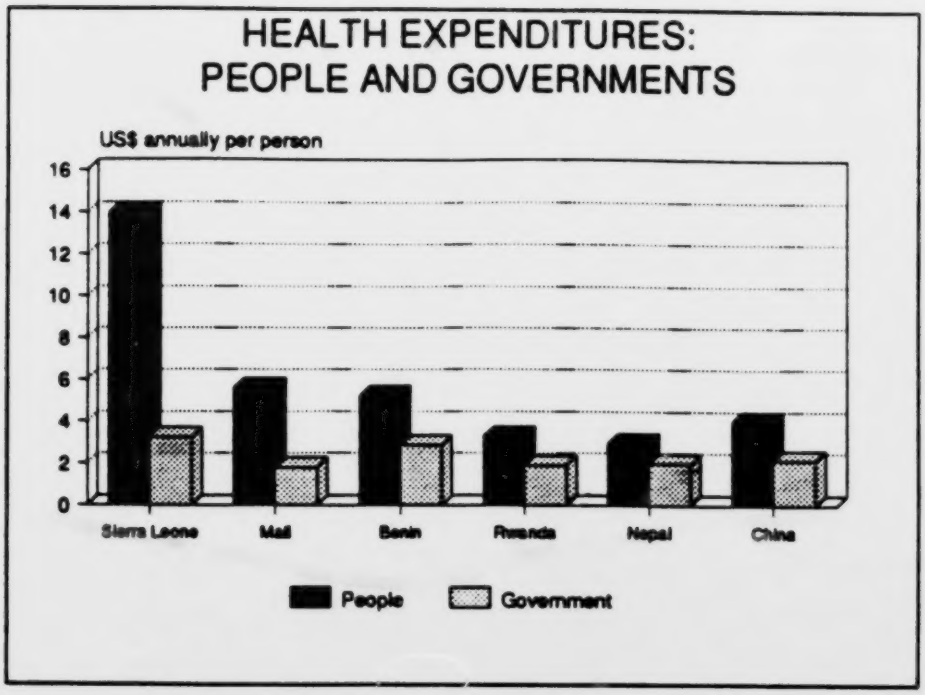
average to a population of about 40,000. Two to three health posts are connected to each centre, but in these, as in the centres, the quality of care is generally poor, exacerbated by low staff morale and the absence of drugs, and overall utilization is very low.

5. In the absence of an effective public sector health care delivery system, people are forced to pay considerable out-of-pocket expenses to obtain care from alternative sources, both formal (private practice or from facilities run by non-governmental agencies) and informal (traditional healers, drug peddlers, market drugs and similar sources). Consistently, people are often paying for health care from their pockets far beyond what Governments contribute to health care delivery.

Figure I



Source: Various (UNICEF, World Bank, others).

The Bamako Initiative as a capacity-building strategy

6. Revitalizing the public sector health care delivery system, based on strengthening district management while capturing some of the resources the people themselves are spending on health, remains the principal aim of the Bamako Initiative. The 36,000 health centres and posts in sub-Saharan Africa are its specific focus of attention in the foreseeable future, with an eventual doubling of this number in the latter part of the decade to increase access to those presently unreached by health care services. Greater awareness of health by the people can undoubtedly have a direct impact on preventing malaria (the use of mosquito nets impregnated with insecticide which can be provided at a cost of under $5), in reducing the problems associated with diarrhoea (the use of oral rehydration therapy combined with continued feeding) and in AIDS prevention (safer sex practices). None the less, the presence of qualified health workers equipped with essential drugs and supplies are key to providing speedy treatment for ARI and proper maternal care, as well as sustaining immunization.

7. During 1989 and 1990, a significant effort had been made to render a limited number of peripheral health centres operational by helping to improve the quality of care and guarantee the availability of essential drugs so that the population would regain confidence in the public system. As predicted, the utilization of the health centres increased dramatically. The sustainability of the service is facilitated by two key factors: (a) the revenue obtained from the sale of services is retained by the peripheral health centres to cover their local operating costs and the resupply of essential drugs; and (b) the funds are managed by health centre committees, which include representatives from the communities served by the health facility. A third element that proved to be key to the Initiative's success is that the essential drugs used by the health centres are generic name drugs that can be supplied at a price that is significantly lower than that being asked elsewhere for equivalent brand name drugs.

8. During 1991, consolidation and careful expansion have remained the hallmark of the Initiative. In Benin and Guinea, some 200 health centres continue to be the focus of action for both countries, with increasing outreach into the villages covered by the centres. Nigeria has maintained Bamako Initiative coverage at over 4 million people, building up a more solid financial base for future action and expanding the number of local government areas covered from 4 to 17. In addition, emphasis on changes in policies relating in particular to decentralization, the control and management of resources at the peripheral level and the importation of generic name essential drugs became much more urgent. In a number of countries, pressure for major reforms mounted as part of the move towards greater democratization. Where external donors joined hands to provide support, their coordinated advocacy contributed to important reforms aimed at the long-term revival and sustainability of basic health systems.

The Bamako Initiative and political instability

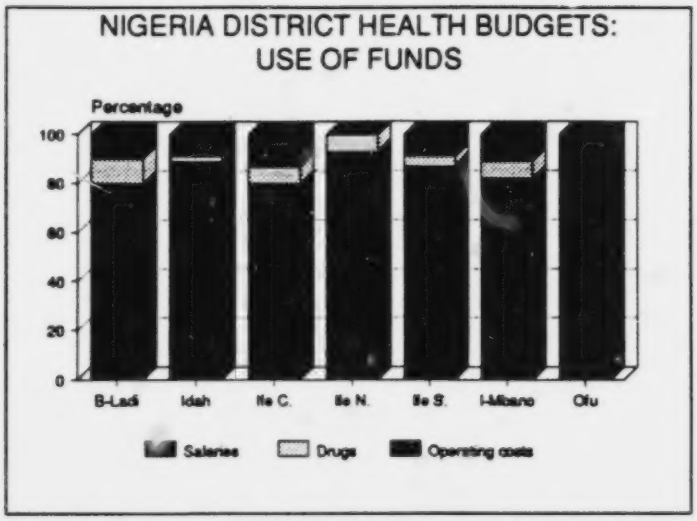
9. Africa is moving towards a decade of great political uncertainty. Democratization movements are having a great impact on the shifting of power and, in some cases, are accelerating policy changes. As yet, however, resistance to policy change is still common in many countries and represents the most significant constraint to the future of the Initiative and its eventual going-to-scale, expanding on some of the positive trends witnessed in action so far. The Ministers of Health of Africa continue to see the Initiative as a central part of their health strategies. At the World Health Organization (WHO) Regional Committee Meeting, held at Bujumbura, Burundi, in September 1991, considerable attention was focused on the issue of health financing and on the potential of the Bamako Initiative to mobilize financial resources in a partnership of Governments with communities, supported by key inputs from external donors. However, the eight principles of the Initiative are still not being addressed uniformly in all cases with appropriate legislation. This resistance is, in part, heightened by the current political transition that Africa is undergoing as entrenched groups become reluctant to accept change. More adherence to the principles will need to be sought as action, no matter how positive, has not been able to produce the policy changes required for the long-term revival and sustainability of basic health systems. More donor dialogue and collaboration will also be important in order to help support policy development and change.

10. The resilience and appropriateness of the Bamako Initiative in times of political instability has been demonstrated in several countries. The strikes and stoppages that plagued Benin in the first half of 1990 reduced the utilization of health centres by only a fraction (1 per cent). During 1991, Sierra Leone has continued to implement the Initiative in the west of the country in spite of the influx of refugees from the war in the east. Cameroon has launched the Initiative in three provinces in the midst of prolonged unrest. Togo, under similar circumstances, has maintained action in all districts of the country. It is clear, however, that where countries start to break down altogether, as in the case of Zaire and, to an extent, Madagascar, logistics systems collapse, causing a stranglehold on the health care delivery system, which is often also the victim of looting and destruction.

The Bamako Initiative and the continuing economic crisis

11. The Initiative aims specifically to rationalize consumer spending in health in an era of declining income and continued economic stagnation in the countries of Africa. Governments are hard pressed to retain past spending levels, which is a basic principle of the Bamako Initiative. This has a considerable impact on the situation of health workers, who are poorly paid or often unpaid for long periods of time. Even in Nigeria, where the economic crisis is not presently so acute, more than 80 per cent of local government area budgets, as seen from seven Bamako Initiative districts, are for salaries, leaving little or nothing for training or supervision costs, which are key tools for health workers to remain skilled and motivated.

Figure II



Source: Data collection in seven Bamako Initiative districts, 1990 (Ministry of Health/UNICEF).

12. Communities in several countries are providing incentives to health workers to raise their motivation to tackle the increased workload that is caused by community involvement in the delivery of services. Incentives vary from $1 to $33 per health worker in the Congo, Guinea, Kenya and Nigeria, assuming equal benefits are paid to all health workers and support staff.

Table 3

COMMUNITY FINANCING: PAYMENT OF INCENTIVES

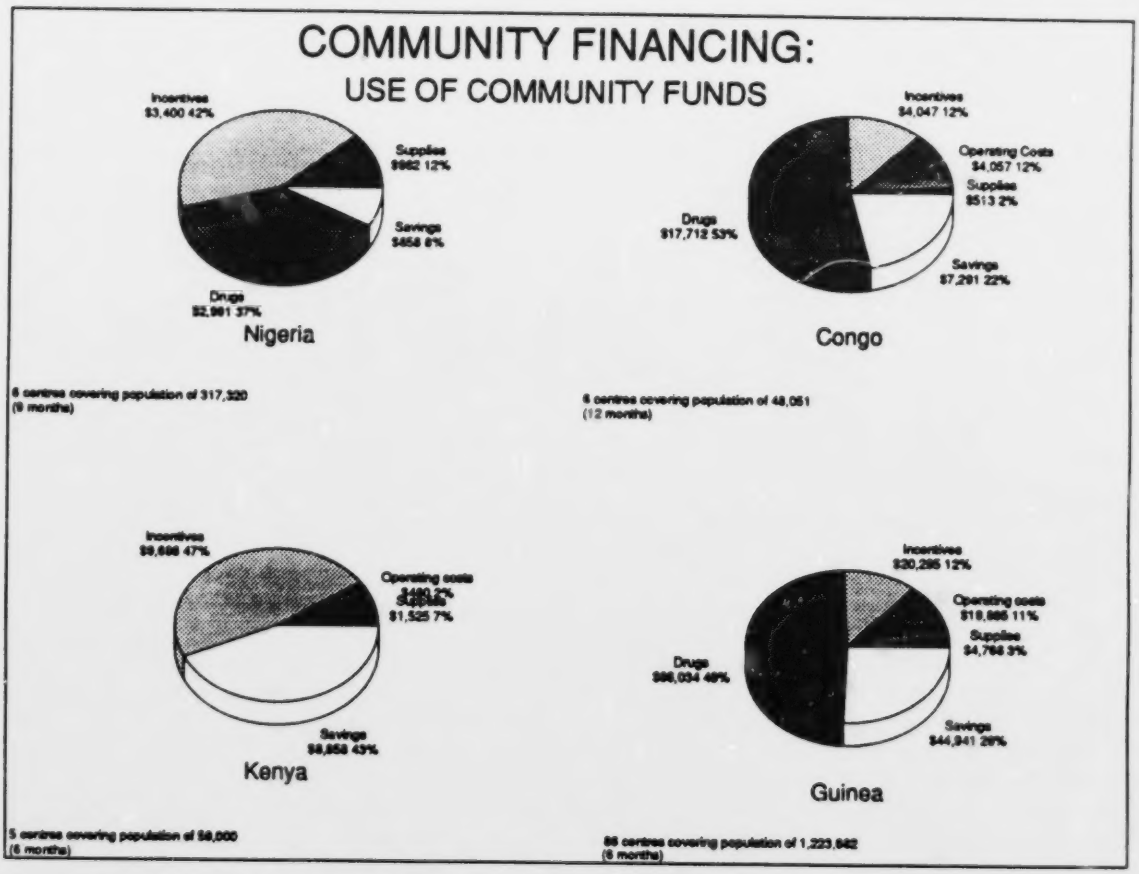
Country	Number of centres	Population concerned	Incentives paid (US dollars)	Period months	Number of facility workers	Average monthly incentive (US dollars)	Range of incentives (US dollars)
Nigeria	6	120,017	3,006	9	37	9.00	4.00 - 20.00
Kenya	2	32,500	9,698	6	123	13.00	3.00 - 19.00
Congo	6	48,050	4,592	12	22	17.00	8.00 - 31.00
Guinea	64	916,541	30,295	6	539	7.45	1.00 - 33.00

Source: Regular in-country data collection (Ministry of Health/UNICEF).

13. Such incentives can begin to reduce the almost universal practice of health workers taking on private consultations "after hours". On a more positive note, a recent assessment in Sierra Leone by the Liverpool School of Tropical Medicine has pointed to the exceptional sense of dedication of health workers in the periphery in the face of great hardship, and this is no less true for a great majority of the nearly 500,000 health workers across sub-Saharan Africa.

14. In the first 44 health centres revitalized in Benin in 1988, the community has consistently contributed between 42 and 46 per cent of the overall operating costs of the centres. For the first 17 centres in Guinea, the community contribution has been between 38 and 49 per cent.

Figure III

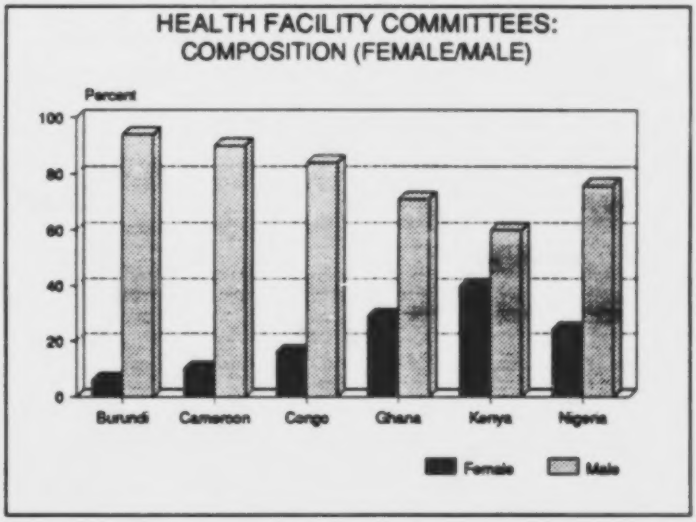


Source: Regular in-country data collection (Ministries of Health/UNICEF).

15. A certain decrease in UNICEF investment has been noted in some instances. Taking, for example, two of the more economically stable countries, Benin and Nigeria, and reviewing UNICEF inputs in essential drugs, there has been a swing since 1989 from direct procurement to reimbursable procurement. A distinct bottleneck, however, is the lack of ability of many government systems to respond to community investment needs, particularly in drug supply. In many countries, central medical stores have been inefficient, often owing to the lack of motivation of their workers, as well as to poor management practices, causing shortages and excessive amounts of expired drugs. Greater attention to this area, including the identification of possible alternative mechanisms, will be needed to ensure more timely drug procurement and distribution.

The Bamako Initiative and the participation of women

Figure IV



Source: UNICEF country office survey 1991. Committees surveyed per country (9, 38, 6, 16, 25 and 54, respectively).

16. Women consistently are members of the health committees which are at the centre of decision-making in the Bamako Initiative. Often, however, this is a token participation, and the extent to which women actually can play a major role in management and decision-making is unclear. Even where there are more than two women on the committee (15 per cent of 53 committees surveyed in Nigeria) or when there are more women than men (7 of 25 committees surveyed in Kenya), there does not seem to have been any significant impact on the performance of the health services in terms of utilization. Monitoring the composition of committees is one of the elements on which more focus will be put in the future. Senegal may well become one of the leaders in women's participation in the Bamako Initiative as women's groups, prominent in

mobilization for the expanded programme on immunization (EPI), will be at the centre of community organization for the Initiative. One aspect that does seem to make a difference in service performance is the presence of female health workers, and this is a particular aspect requiring more careful study and eventual advocacy.

The Bamako Initiative and equity

17. Even with a considerable increase in the amount of data available, there is still little concrete evidence as to the number of exemptions being made to payment at health centres, often because there is a reluctance on the part of both the providers and consumers to acknowledge such action. Continued observation has indicated that community solidarity does exist with regard to the poor. The provision of credit to patients in Mauritania is an indirect indication that people are being treated and that eventually the community itself will cover the credit. This is particularly apparent in the desert villages that give treatment to nomadic groups. A more systematic attempt to quantify equity will be undertaken in 1992, while recognizing that barriers to data collection may well exist.

II. COUNTRY ACTIONS

18. By late 1991, 18 countries constituted the core group implementing the Bamako Initiative. UNICEF support, in collaboration with other international donors, is centred on a population of about 20 million in over 200 districts. Some of the donors, notably bilateral cooperation from Germany, France, Belgium, the Netherlands and Switzerland, as well as from the World Bank, the European Economic Community (EEC) and some non-governmental organizations (NGOs), are covering additional districts in implementing the Initiative in many of these countries.

Table 4

BAMAKO INITIATIVE COUNTRIES SUPPORTED BY UNICEF IN 1991

Country	Total number of districts	Number of Bamako Initiative districts	Population coverage	Number of health facilities
Benin	83	50	1,000,200	170
Burundi	34	1	300,100	14
Cameroon	49	30	799,800	45
Central African Republic	16	6	400,200	56
Congo	39	1	142,300	7
Ghana	110	3	493,000	23
Guinea	38	36	2,800,000	193
Guinea-Bissau	8	1	130,300	15
Kenya	43	8	600,000	34
Mali	46	31	1,400,000	196
Mauritania	13	4	250,000	17
Nigeria	453	17	5,700,000	534
Rwanda*	10	10	1,450,000	67
Sao Tome and Principe	7	7	120,000	34
Senegal*	30	3	600,000	54
Sierra Leone	13	5	1,100,000	333
Togo*	21	21	602,400	70
Zambia	55	7	764,900	50
TOTALS	1,048	221	20,826,400	1,794

* Bamako Initiative districts - partial coverage.

Source: UNICEF country office data.

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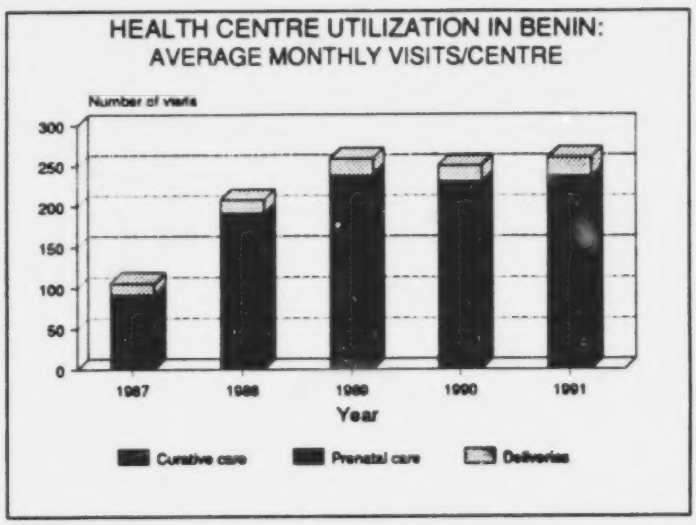
Benin

Figure V



Source: Bamako Initiative monitoring system, Ministry of Health/ UNICEF, 1987- 1989 (44), 1990 (155), 1991 (186).

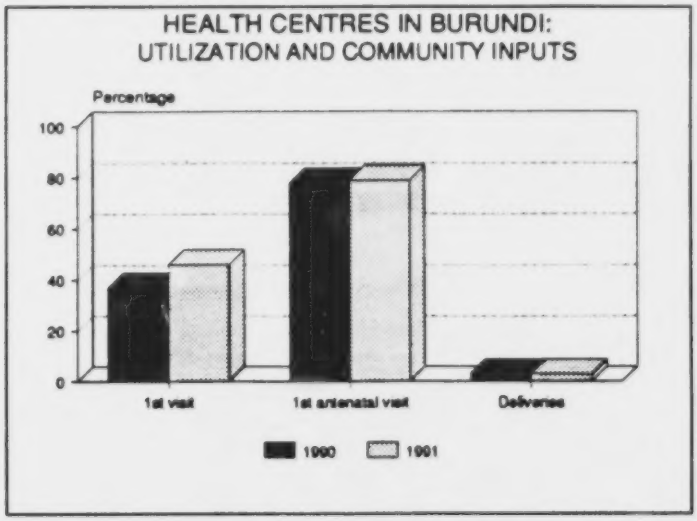
19. Utilization of the health centres in Benin has maintained past performance, with a continued steady trend in the increasing use of services for antenatal care and deliveries, even with new centres coming on board. It would seem, however, that a certain "maximum level" of utilization has been reached, equivalent to about 0.3 first visits per person per year, and that a significant proportion of the population continues not to use the public sector health centres even with the community involvement that exists. There is every indication that this is due mainly to access limitations and that the centres are fully covering the immediate population, but less so the more distant inhabitants. Outreach from health centres has had a noticeable impact on immunization coverage, but less so on antenatal care and attended deliveries. Interestingly, however, urban centres, where access is high, have also reached a stable level of utilization mainly because the population has access to other means of care, including private practitioners. Improved planning and resources management at the district level, still a relatively weak aspect to action in Benin, will be key to addressing the coverage of populations falling outside the immediate catchment areas of the health centres.

20. Information resulting from regular monitoring has proved to be a crucial management tool, increasing the capacity of both health staff and community representatives to make decisions. A broader community-based information system, collecting and analysing basic health and nutrition information, is being established, initially on a small scale, to help increase awareness at the village level of the health and other problems being faced.

Burundi

21. After officially adopting the Initiative in December 1990, action in 1991, supported jointly by UNICEF and WHO, concentrated on developing a strategy of strengthening primary health care (PHC) based on improving the quality of care in health facilities and the control of resources by the communities. Action started in nine public sector health centres (population 260,000) and five private clinics in Muyinga District, with community management committees formed and trained in each centre. A 24 per cent rise in utilization of the centres for curative care was seen in the first half of 1991, although little increase was experienced in prenatal care or deliveries at the centres.

Figure VI



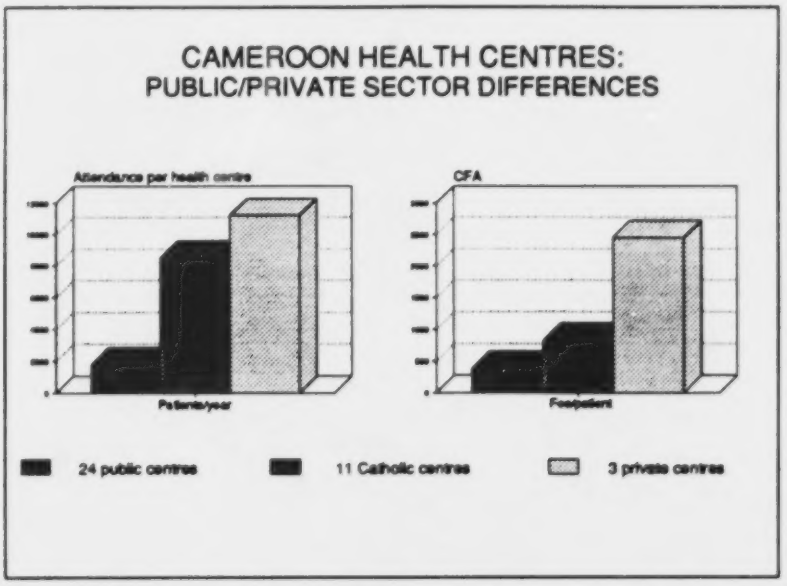
Source: UNICEF-supported survey (nine health centres (1991 population 260,000)).

22. Community health financing in Burundi is based on a prepayment system (carte d'assurance médicale). The Bamako Initiative aims to popularize further this method of payment, although the recent United Kingdom/Overseas Development Administration (ODA)-sponsored evaluation has indicated that this system may not be able to contribute significantly to the costs of care and that the very poor might find it more appropriate to pay fees rather than to prepay for care. A follow-up study on service costs and resource availability will analyse this issue more in depth.

Cameroon

23. The Bamako Initiative was launched officially in July 1991, after nearly two years of preparation. In a survey of 62 health centres, 39 from the public sector and the rest non-governmental, carried out before the launch, it was clear that the performance of the public sector was very low in terms of patient utilization, owing largely to a complete absence of drugs. In contrast, Catholic Mission-run centres, although charging on average about $3 per first visit, were outperforming the public sector centres; in all, only 6 of 23 non-governmental centres reported any shortages of drugs during the year, but for periods mostly well under 30 days.

Figure VII



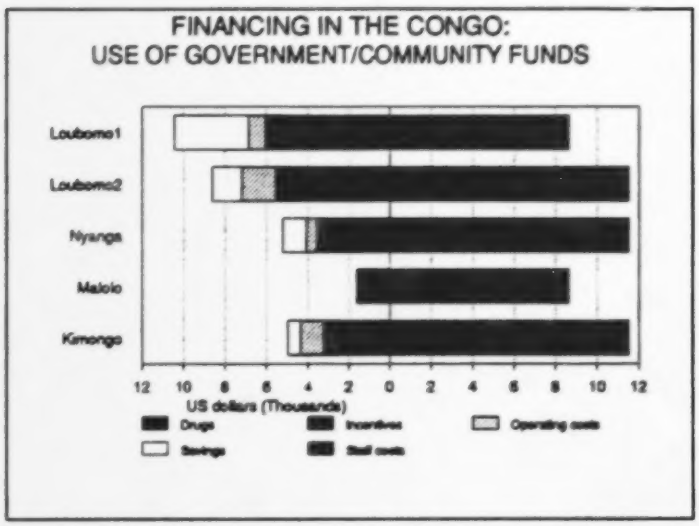
Source: UNICEF-supported survey, data from 38 health facilities, 1991.

24. UNICEF is focusing its support on three provinces, with other donors such as the German Agency for Technical Cooperation (GTZ), EEC and the United States Agency for International Development (USAID) covering other provinces with a support calculated at $8.5 million, all within the new direction in health sector development that takes its foundation from the Bamako Initiative. An intersectoral coordinating committee meets twice a year to oversee this health effort. While some set-backs have been experienced, particularly a 12 per cent reduction in the country's health budget between 1990 and 1991, the PHC and essential drug budgets have not changed, although these only represent 9 per cent of the total. On the positive side, the UNICEF provision of drugs costs between 40 and 50 per cent less than at private pharmacies, thus allowing families lower expenditures on health care.

A start has been made in assessing more closely the mobilization and communication needs of the Initiative in Cameroon, with a view to adapting the findings to other countries implementing the Initiative.

Congo

Figure VIII



Source: UNICEF-supported survey, five GTZ-supported health centres, 1990.

25. The Bamako Initiative was included in the proceedings of the National Conference that led to the adoption in the Congo of a multi-party system, recommending that the transitional Government use this basis to formulate a national health plan. At the same time, UNICEF, with WHO, GTZ, EEC and French bilateral cooperation, advised the Ministry of Health of ways to reorganize itself for this new plan. With GTZ support, five communities with a population of 151,000 had already initiated action similar to the Bamako Initiative, with four of the five already able to contribute the cost of drugs used. An additional 12 centres are being incorporated in Brazzaville, with UNICEF support, covering 115,000 people. A rapid acceleration of the Initiative is expected, with the adoption of the national plan and reorganization of the Ministry of Health. A national coordinating committee, with the participation of all the appropriate donors in the health sector, has been set up to lead this action. UNICEF is presenting a new country programme recommendation to the 1992 Executive Board (E/ICEF/1992/P/L.8) that envisages a coverage of 40 per cent of the population with the Initiative through a strengthening of 74 health centres.

Ghana

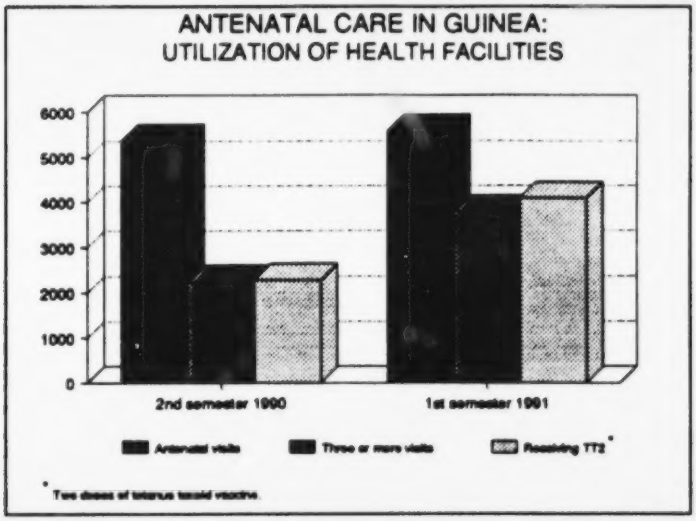
26. Ghana spends a relatively high proportion (24 per cent) of its national health budget on PHC and has continued in the decentralization effort, designating districts to bear the final responsibility for their own development. This has been supported with increasing financial authority for the district administration. National leadership in the Bamako Initiative remains weak, with the absence of any national steering committee. In spite of this, the Initiative has taken hold in five districts (483,000 population), two being operational, with 14 health facilities covering 204,000 people, and the other three with 13 centres still in a preparatory stage. Previous studies in Ghana had shown that the introduction of user fees had led to a drop in utilization. Following the introduction of the Initiative, however, there are indications that service utilization has begun to improve, owing not to different fee structures, but to the ensured availability of drugs. A management information system is being introduced in the five districts, including data on utilization, diagnosis, drug use and financing. This will provide more precise data on utilization, which is important given past experience and because of the very poor utilization of some services (only 5 per cent of pregnant women come to the health centres for delivery).

27. Collaboration with WHO is effective in Ghana and it is expected that the work of the Operations Research Unit of the Ministry of Health, funded partly by the United Kingdom/ODA, will be supported by UNICEF in upcoming years to cover operations research that is key to the implementation of the Initiative, particularly on the possibility of introducing district insurance schemes as an alternative to user fees.

Guinea

28. The United Kingdom/ODA-sponsored evaluation has confirmed the positive results achieved in Guinea over the last three years in terms of revitalizing health services that were previously almost totally non-functioning, with an acceptable level of primary care and a decided community role in managing the centres. Further expansion in 1991 brought the number of centres under the Initiative to 192, covering a nominal population of about 4 million people, although because of access difficulties the effective coverage estimated to be between one third to half of this figure.

Figure IX



Source: Bamako Initiative monitoring system, 16 centres with comparative data available Ministry of Health/UNICEF.

29. While the utilization of services in Guinea has been variable (some increase, some decrease), a positive trend is emerging, as seen in recent data, in a greater retention of women in antenatal care and a higher level of tetanus toxoid immunization. Also of interest is the fact that the basic essential drugs cost for the centres is relatively low, the equivalent of $270,000 for 185 centres for one year (June 1990 to May 1991), or $1,460 per centre. This, however, raises the question as to the effective coverage of the centres and the need to expand outreach beyond immunization and growth monitoring services. Of concern also is the aggregated community investment fund of the equivalent of $800,000 in local currency, still held in interest-bearing bank accounts awaiting the political decision regarding its conversion to foreign exchange leading to the purchase of essential drugs.

30. Training activities in Guinea in 1991 highlight the intensive work nature of the Initiative. Overall, 36 prefectural health directors, 36 district health planning officers, 180 heads of health centres and 180 community committees and key staff at national and regional levels have received training in such areas as random survey techniques, communication, planning, services management, essential drugs management, EPI, the control of diarrhoeal diseases, monitoring and the use of simple registers.

Kenya

31. During the last year, action in Kenya has expanded to cover 34 communities in eight districts. Popular demand for the Initiative, which is built on the traditional communal work pattern of harambee and involves the

training of village health workers and community management of a small pharmacy, all under the supervision of health centre and dispensary staff, is high. This has raised the challenge to the government capacity to train and supervise relative to the communities' desire to improve their health situation. Both the United Kingdom/ODA-sponsored evaluation and an assessment made by the Royal Tropical Institute in Amsterdam on behalf of the Government of the Netherlands have raised the question as to how fast the Initiative can expand in Kenya. The malaria control programme, which is a central element of the Bamako Initiative in Kenya, provides a major impetus to local action, especially the provision to communities of low-cost mosquito nets impregnated with insecticide.

32. The capacity of communities to cover very basic health care costs has been established over the past two years. Table 5 below examines two of the original communities in terms of the use of community funds and shows how they take their own decisions on priorities.

Table 5

KENYA: USE OF COMMUNITY FUNDS

Place	Population	Monthly revenue	Supplies	Operating costs	Incentives CHW/TBA*	Drugs	Savings
		(In United States dollars)					
Sigoti	18,500	2,031	9	4	1,536	0	482
Kasongo-Masogo	14,000	977	243	52	80	0	375

* Community health worker/traditional birth attendant.

Source: Community logs.

33. To date, there have been no expenditures on drugs since the initial supply is being provided through UNICEF. From the above figures, it can be seen that revenue has reached between $0.80 and $1.30 per person per year.

Mali

34. The large health, population and rural water supply project, involving the World Bank, UNICEF, USAID and EEC and eventually covering five regions, started in 1991 with a solid foundation. After some initial problems, in addition to the change in Government, regional plans have begun to be prepared under the guidance of a UNICEF health adviser in each of three regions initially. This involves 21 districts, including 6 in Bamako, with an overall population of 4 million, although in the first year of implementation, 1992, only 12 districts (4 in Bamako) will benefit directly. Collaboration with WHO on a health information system and other activities has begun. Considerable

work in legislation is under way, particularly on an essential drugs policy. As one of the conditions of the World Bank loan, communities have now officially been given the power to organize themselves and to manage their own resources locally, and the decentralization of management of the health services *has been agreed upon*.

35. Great potential exists for the Initiative in Mali, especially because of the high degree of donor collaboration. UNICEF, with EEC, is also supporting the preparation of a plan to implement the Initiative in the two northern and most isolated regions of Gao and Timbuktu, following on from work both agencies have been involved in there with the direct participation of NGOs.

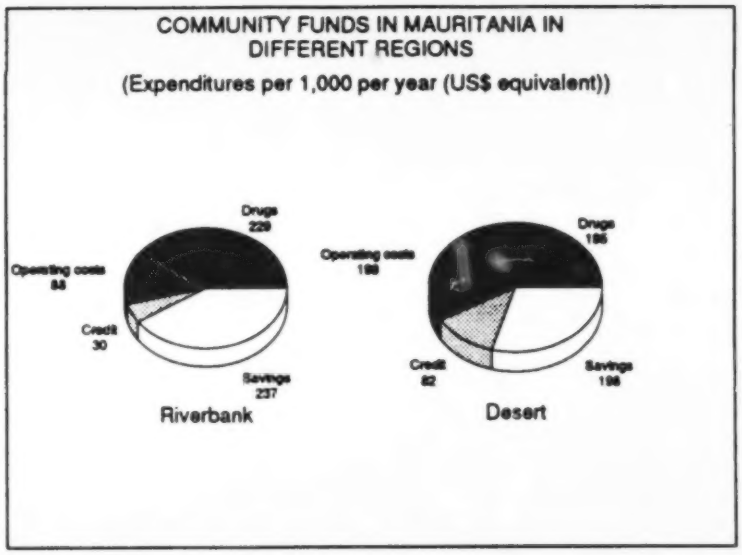
Mauritania

36. The Ministry of Health and Social Affairs took additional steps in 1991 to improve sectoral organization and management, with the Council of Ministers approving a decree authorizing community financing and management of health through local committees attached to each health facility. Additional measures, mainly as a prerequisite for a World Bank loan (health and population project), are being introduced in 1992, including the decentralization of health system management, mobilizing resources for the regional health system, strengthening capacity at the central level and establishing an essential drug policy. All these follow the basic policy guidelines of the Bamako Initiative. A broad-based alliance, including the World Bank, UNICEF, WHO, the United Nations Population Fund (UNFPA), GTZ, the African Development Bank, French bilateral cooperation, EEC, Terres des Hommes, World Vision and Association Française de Volontaires du Progrès, is working towards a revitalization of the health sector and its extension through community-based workers.

37. UNICEF has concentrated its support on national capacity-building as well as on specific action in two health centres, 1 medical post and 19 villages (population: 47,000). Considerable assessment activities have been carried out, indicating, for example, that the cost of the average consultation at the community health worker (CHW) level is approximately $0.40, compared with $1.15 at the health centre level. It has been calculated that for every 1,000 people, about 200 visits to a health centre can be avoided by having a well-trained and supervised CHW in the village with a small stock of drugs. This would mean considerable savings to the household, especially in transport, given the large distances at which remote desert villages are located from health facilities (40 to 50 kilometres on average); a possible savings of up to $30 per family per year on health costs through a properly functioning village/health centre network.

38. There appear to be differences in health care costs between those communities close to the Senegal River (pastoralists) and those living inland in the desert. The latter have higher costs, exacerbated to an extent by nomadic groups receiving health care and sometimes being unable to pay. Utilization in the river areas is also higher owing to the high incidence of malaria, leading to a higher consumption of drugs.

Figure X



Source: UNICEF-supported survey, 1990-1991 (12 riverbank and 7 desert villages).

Nigeria

39. By mid-1991, Nigeria had reached 4.1 million people in 17 local government areas with the Bamako Initiative. Since 1989, the cost of this has been $5.2 million, $2 million of which was supported by the Government of Nigeria. Another six local government areas with 1.6 million people are presently carrying out preparatory activities in situation analysis and training. Decentralization from the federal level to the local government areas is a strong feature of the Initiative in Nigeria, taken within the overall priority in the country for strengthening PHC. Direct resource allocation to the local government areas from the Federal Government was increased from 10 to 15 per cent, although the percentage of the national budget for health declined in 1991. The main portion of state and local government area budgets are allocated to PHC; thus, in the country about one third of health funds are spent in PHC. Cost-sharing in the health sector is now practised throughout the country. The Bamako Initiative is bringing better management and community control to health sector development in the local government areas, making them a model for cost-effectiveness.

40. The organization for the Bamako Initiative is rigorous, with committees at all levels of the health care system. At the national level, a National Bamako Initiative Consultative Committee, chaired by the Minister of Health, reviews policies and strategies. Both UNICEF and WHO are active partners with the Ministry of Health in a tripartite committee, which meets quarterly to review issues, provide planning guidelines and recommend specific

collaborative action. An operational committee meets monthly to follow up progress and take corrective action when necessary. A specific unit in the Ministry for the Initiative develops work plans and is involved with implementation. Every local government area has a PHC committee, and individual communities have development or health committees. There are also intermediate committees at the district level (between local government area and village). The United Kingdom/ODA evaluation of Nigeria has noted that there was clear evidence of community participation in the Initiative, cautioning, however, that increased demand created by the initial success of the Initiative will be a challenge to be met.

Rwanda

41. People have been paying for health care in Rwanda since 1974. Funds collected by the health centre are given to the subdistrict (commune) administration, which has used them mostly for purposes other than health. Hospital fees are given directly to the National Treasury. Generally, although people have been paying fees, they have had to buy drugs in private pharmacies because of the lack of drugs in the public system. The Bamako Initiative, which has been initiated in 67 public sector health centres located in 58 communes, aims to change the management of funds so that they are retained for reinvestment in health and to ensure a basic supply of essential drugs in the centres to attract greater community involvement. Over four years, it is expected that these management changes will have taken place in all 258 health centres in the 145 communes in the country to bring them up to the level of the health facilities run by church organizations (45 per cent of the facilities in the country) where drugs are sold at reasonable prices and where the quality of care is considered better.

42. The commune is the key administrative level in Rwanda. The Initiative is setting up community management committees to help manage health facilities and interact with the commune administration. Each commune has an annual budget of $600 a year which can be used for any relevant expenditures related to those individuals designated as indigent. This exemption scheme is considered a key component for retention by the Bamako Initiative.

43. One of the main immediate actions by the Initiative is to improve the drug procurement and logistics system to meet the drug needs of the centres coming under the Initiative. A health information and monitoring system is also under review. The legal status of the community management committees is another action subject to urgent action.

Senegal

44. Preparatory action for the Bamako Initiative took place in 1991, leading to the initiation of activities in three districts in 1992. By the end of 1992, it is envisaged that 54 health centres, covering around 600,000 people, will be operational under the Initiative. This action forms part of the Government's operationalization of the 1989 Declaration of a National Health Policy, for which the World Bank is providing a loan (human resources

development project - health and population) aimed at developing district health systems, ensuring essential drug supply and the strengthening of institutions in the health sector. A schedule of activities has been finalized for the World Bank project and the monitoring of implementation has been entrusted to an in-country donor group involving all major donors in the health field, including UNICEF, and coordinated by the Belgian Embassy. In 1991, the preparation of district and regional health development plans has been the main focus of attention.

45. The role of UNICEF in this larger picture is in following the principles of the Bamako Initiative, which have been adopted by the Government, focusing especially on the involvement of communities in the local management of services. The experience of EPI in community mobilization, which included women's associations, serves as the basis for continued action, with a broader set of essential services made available in order to optimize costs, respond to the demand of communities and sustain immunization coverage. By mid-decade, it is expected that UNICEF will be supporting the Initiative in 11 districts, covering 1.8 million people, as indicated in the country programme recommendation (E/ICEF/1992/P/L.10).

Sierra Leone

46. Despite considerable difficulties, including a complex emergency situation in the east of the country and the loss of half of the country's export earnings, the Bamako Initiative advanced in 5 of the 13 districts, although at a slower pace than had been envisaged. By end-1991, concerns were being raised about the availability of funds for essential drugs, as less and less funds were being deposited with UNICEF for reimbursable procurement in line with the action started in 1986 in this regard. In the three original Bamako Initiative districts, funds were transferred directly to UNICEF for drug replenishment, thus consolidating progress already achieved in community involvement based on cost-sharing. One breakthrough was the agreement by the Ministry of Health to the retention at the community level of some of the funds generated at that level through user fees. About 20 per cent of local funds are retained for the upkeep of health facilities and to offset the cost of providing services to those who cannot pay. A recent survey of 263 existing community committees by the Ministry of Health Planning Unit, WHO and UNICEF, reinforced previous findings that such committees can effectively manage community funds.

47. Research work on health financing has detected key constraints such as the seasonal availability of cash and the ubiquitous nature of drug peddlers. A longer-term research effort is presently under consideration, looking at the critical issues determining the quality of care from both the providers' and users' perspectives.

48. Although contacts with other donors increased, notably a new three-year agreement between UNICEF, WHO and UNFPA for maternal and child health/family planning action, up to last year UNICEF has been the main financier of the Initiative.

Togo

49. After two years of deliberation, the Bamako Initiative became operational in January 1991, aided by a new national health and population programme, with community participation in health financing and management as one of its bases, a national drug policy, approved in 1990. The decentralization of the health system started at the beginning of 1991 and the initial experience of the Initiative in 21 peripheral health units which had begun to prove that communities could effectively manage resources leading to their covering drug and local operating costs. In 1991, coverage of the Initiative expanded to include 118 peripheral health units, 78 supported by UNICEF and 40 by GTZ, covering a total population of 603,000. An additional 64 peripheral health units will be covered in 1992, benefiting another 320,000 people and reaching an overall population coverage of 25 per cent.

50. Essential drugs lists now exist, as do diagnostic and treatment charts, for use by the health workers. The monopoly of Togopharma, the drug distribution centre, was broken, allowing for new ideas as to how to establish an effective drug supply and distribution system. It is expected that this will be forthcoming in the next year.

Zambia

51. The past year has been one of intensive preparation for the start-up of the Bamako Initiative in seven districts. There is a growing emphasis on district strengthening with the support of several agencies such as UNICEF, WHO, the Swedish International Development Authority and the Government of the Netherlands. This is being accelerated by the new Government, which has also set up a national health financing group to review the whole sector and to make recommendations for restructuring. Critical factors in both decentralization and financing will be staffing, training and supervision. The overall trend in the country is towards systems of user participation in financing with the retention of revenue at the level generated. The experience of NGOs in this regard will be an important lesson for new financing policies. In looking at three public sector rural health centres, the degree of community support for health care financing has been quite low ($0.04 to $0.17 per person per year).

52. With regard to drugs, Zambia benefits from a national formulary. For health centres and CHWs, 36 and 6 drugs, respectively, are listed for use. Community involvement is being promoted through the training of community leaders, as well as through some links to local income-generating activities. It is expected that in 1992 all preparatory activities will move to an action phase of the Initiative.

Table 6

CONTRIBUTION TO HEALTH CENTRE COSTS

Location	Population	Total visits/annum	Government	Donors	Community
			(In United States dollars per year)		
Nampeyo	10,000	13,200	0.38	0.45	0.17
Hakunkula	11,000	14,400	0.32	0.45	0.08
Keemba Hill	75,000	12,000	0.40	0.24	0.04

Source: Bennett, S. and Musambo, M., "Report on community financing and district management strengthening in Zambia", UNICEF, 1990.

Other countries in sub-Saharan Africa

53. In the Central African Republic, national policies of decentralization and community participation are being actively promoted as preparatory work for the Initiative, as is the harmonization of the various approaches supported by donors in the health sector. The National PHC Committee in Equatorial Guinea has continued to take preparatory action for the Initiative, concentrating on developing district health profiles, establishing legislation for decentralization, preparing an essential drugs list and evaluating NGO revolving drug fund schemes. Implementation is expected to begin in early 1992.

54. The Bamako Initiative in Guinea-Bissau is being implemented in Gabu Region, with increasing community involvement in the running of base health units. Utilization in the units has doubled, with people willing to pay for drugs as long as they retain confidence in the supply system. The average cost per treatment has been calculated at $0.50. Communities have been able to contribute 39 per cent of the running costs, equivalent to 87 per cent of drug costs. Interestingly, prepayment (abota system) only appears to account for 9 per cent of community contributions to health units, indicating that there is still a lack of confidence in the health unit being able to provide long-term, quality service to the population. Extensive preparatory action has taken place in Sao Tome and Principe, although decisions at the national level still need to be taken on key issues such as the community control of funds, community organization and mechanisms to improve health system management. The World Bank is supplying essential drugs to the country for four years based on cost-recovery principles, thus allowing the Bamako Initiative to focus on the whole country. Considerable work has been completed on establishing drug lists at each level, sample prescription

sheets, pricing mechanisms and an inventory system. WHO is instrumental in supporting the formation of district health committees. A rapid acceleration of implementation is expected in 1992.

55. In the upcoming year, Côte d'Ivoire will implement the Bamako Initiative in 6 of the 26 regions in the country with UNICEF support, as noted in the new country programme recommendation (E/ICEF/1992/P/L.9). By mid-decade, with the support of other donors, national coverage of the Initiative should be achieved. The Gambia is also presenting a recommendation to the 1992 Executive Board (E/ICEF/1992/P/L.30), including support to the Bamako Initiative. In 1992, a start will be made at two health centres to test ways effectively to decentralize decision-making and the management of funds and to stimulate community involvement in the management of the centre through the village development committees. A national workshop in Lesotho in September 1991, attended by a wide range of organizations involved in health development in the country, produced a series of recommendations on the importance of the Initiative, including the reconstitution of the National Task Force to invigorate leadership for start-up action in 1992 in a selected number of health service areas. Support to the Initiative is included in the new country programme recommendation being presented to the 1992 Executive Board (E/ICEF/1992/P/L.3).

56. An increasingly favourable climate for implementing the Bamako Initiative in the Sudan is developing, especially with the adoption of a federal system of Government leading to greater decentralization and increased budget autonomy at the level of rural councils. Although initial implementation was due to begin in Kordofan State in 1991, the severe drought there delayed action. By mid-1992, action for 650,000 people in four health areas should be under way.

Countries outside Africa

57. Action along the lines of the Bamako Initiative will start in five districts in different regions of Nepal in 1992, as described in the new country programme being presented to the 1992 Executive Board (E/ICEF/1992/P/L.25). The objective is to strengthen the operation of health posts in those districts, improving the quality of service through health worker training and ensuring a supply of essential drugs, both of which will encourage communities to invest in these posts through locally controlled financing. Viet Nam has been working in a similar way in six districts since 1990, with a specific focus in 1991 on the provision, management and promotion of the rational use of essential drugs in three districts. The rapidly changing nature of economic reforms in the country, however, is having an impact on the ways social services are being provided and, to date, community financing has not been able to cover essential drug costs, partly because of the low management capacity of the commune health staff and the relatively low level of involvement of the people themselves. A recent Save the Children Fund (United Kingdom) assessment of community financing has cited affordability problems for many of the people at a time when costs of providing health care are rising and medical supplies are dwindling. It is

considered that a more in-depth review of the Vietnamese health system might be necessary to identify more clearly alternative options for future, more sustainable action.

58. Health services in Myanmar face increasing problems of access, service quality and financial sustainability. There has been attention in recent years to options for greater local financing of care, using revolving fund approaches to meet essential drug needs. A first assessment of the Bamako Initiative in the Myanmar context has taken place and further steps are being studied.

59. Some initial discussion of the possible relevance of the Bamako Initiative principles in Cambodia has been initiated, especially on the possibility of communities taking a greater role in the management of health services, including remuneration for health workers. China has increased its review of financing alternatives in the health sector and has shown some initial interest in the community financing approach of the Bamako Initiative, as well as in the broader consumer insurance plans as implemented on a non-profit basis in some industrialized countries.

60. A first assessment of several small community financing schemes in Honduras has indicated the need above all for a national essential drugs policy and for initiating the use of generic drugs to reduce costs. In Peru, preparatory work for starting action along the lines of the Bamako Initiative in three distinct urban areas highlighted the low utilization of public sector health services. People complaining of the poor attitude of health workers prefer to use private pharmacies for diagnosis and treatment or take herbs (a situation very similar to Africa).

Table 7

PERU: CHOICE OF PROVIDER

(Percentage utilization)

	Diarrhoea	Common cold	Respiratory infection
Traditional medicine	33	11	5
Private pharmacy	23	43	35
Other shops	10	17	6
Health centre	3	2	11
Higher-level health service	7	2	24
Private doctor	17	12	16
No treatment	7	13	3

Source: UNICEF-supported survey, 1991.

61. Peru is presenting a new country programme recommendation to the 1992 Executive Board (E/ICEF/1992/P/L.18), including action in health along the lines of the Bamako Initiative in four health regions, taking into account the lessons of the preparatory stage, especially the need for a government/ community partnership in decision-making and the management of resources.

III. DONOR INVOLVEMENT

World Health Organization

62. At the headquarters level, increasing contacts have been made with the Drug Action Programme, holding joint technical meetings, as well as with the Strengthening Health Systems Group, particularly in work on the joint paper entitled "Management of the district health system based on primary health care", presented at the UNICEF/WHO Joint Committee on Health Policy meeting, held on 30 and 31 January 1992. Also being pursued is an increasing collaboration in health systems research, examining key elements that affect the effectiveness and efficiency of the public sector health care delivery system in sub-Saharan African countries such as resource availability and use, community involvement in systems' financing and management, service quality and the strengthening of district health teams to support peripheral services. The WHO/Netherlands Ministry for Development Cooperation/Royal Tropical Institute Project on Health Systems Research, based at Harare, is an important network with which UNICEF-supported action could be coordinated.

63. At the regional level, periodic contacts between UNICEF and WHO Regional Directors have continued. The Regional Committee Meeting also focused on the financing of health systems, and the role of the Bamako Initiative was pronounced as key to the mobilization of community resources for health. At the country level, there is widespread collaboration, although the exact extent of this varies from country to country.

World Bank

64. Following the global memorandum of understanding signed between UNICEF and the World Bank on January 1991 on joint collaboration on the Bamako Initiative, Mali, Mauritania and Senegal have become the subject of joint action. Mali constitutes a formal agreement between the agencies and the Government; UNICEF has already increased its technical capacity in-country to support the work of provincial medical teams in planning, management and supervision. In Senegal, convergence between the work of the two agencies has been agreed upon, while joint preparatory work has been taking place in Mauritania with, in the latter case, a joint assessment leading to the conclusion that more attention would be focused on Nouakchott given the increasingly difficult conditions of the marginal urban settlers. Joint preparatory work has also been initiated in Guinea-Bissau and Burkina Faso. In the latter, five agencies (UNICEF, the World Bank, WHO, the United Nations Development Programme (UNDP) and UNFPA) have signed a joint call to the Government to establish a national essential drug policy.

65. It is likely that a limited number of countries will be highlighted in this increasing UNICEF/World Bank collaboration, although considerable ongoing country cooperation between the two agencies is taking place. At the headquarters level, UNICEF will also be involved in the World Bank work on preparing an African health policy study.

Other donors

66. Donor alliances are increasingly common in many of the countries implementing the Bamako Initiative, including multilateral and bilateral agencies and NGOs. However, the degree to which they work harmoniously or at cross-purposes varies. This issue is visible, for example, in donor support to the provision of essential drugs in which close coordination exists in some countries in working towards a national essential drugs policy (one of the Initiative's basic principles), while in others drug donations are given with little regard to policy or even rational use. Part of this reflects the relative weakness or lack of interest of recipient Governments to coordinate external support.

67. During the year UNICEF has maintained close contact with major donors to African health activities. Less attention than desired, however, was given at the global level to NGOs, a factor that will require more attention in 1992.

68. UNICEF, as recommended on several occasions by its Executive Board, has continued to mobilize general resources for the Bamako Initiative. During 1991, this included $7,464,000 for 13 countries as general resource allocations against unfunded supplementary funding proposals. The Bamako Initiative Global Reserve has continued to be used for preparatory action in selected countries: $1,460,000 for eight countries. Additional supplementary funding was received in 1991, notably $5 million from the Italian National Committee for UNICEF for action in Mali and Senegal and $2.5 million from the Government of the Netherlands for action in Kenya.

69. It is already predicted, however, that UNICEF will be increasingly strained in upcoming years to continue to meet the financial demands of the Bamako Initiative. The generation of supplementary funds within Executive Board approved programmes is now critical in order to respond to the efforts of the Governments and communities of Africa in this action which is fundamental to the achievement of the goals for the 1990s.

70. It has been interesting to note that out of the UNICEF investment in the Bamako Initiative, the amount spent on essential drugs is relatively low. This is partially explained by the fact that most drug needs are low cost and also by the importance of other inputs mainly concerned with improving management and logistic systems.

Table 8

UNICEF INVESTMENT IN THE BAMAKO INITIATIVE:
BAMAKO INITIATIVE DEVELOPMENT FUND (FUNDED)

(In thousands of United States dollars)

Country	1988	1989	1990	1991	1992	1993	1994	1995	Total
Benin		400	85	1,351	85	85	85		2,091
Burundi		209		1,135					1,344
Central African Republic				368					368
Cameroon		260		397	597	297	255	255	2,061
Congo			42	270					312
Equatorial Guinea			44	350					394
Ethiopia		330							330
Gambia				240					240
Ghana		2,000		188	184	425	432	440	3,669
Guinea		400	1,000	830	830	780	730	730	5,300
Guinea-Bissau				360					360
Kenya		200	90	862	1,684	524			3360
Madagascar				220					220
PMali			300	2,290					2,590
Mauritania		400		238					638
Niger				300					300
Nigeria		600	2,000	3,092	1,959	2,155	1,847	1,909	13,562
Peru			250						250
Rwanda		150		800	600	600	600		2,750
Sao Tome & Principe			35	180	150	150	150	150	815
Senegal				2,790					2,790
Sierra Leone		600	531	1,631	785	765	770	745	5,827
Sudan		200		150					350
Togo				2,147	490	470	470		3,577
United Republic of Tanzania		40							40
Viet Nam				250					250
Zaire			400						400
Zambia				102	80	80	80	80	422
Subtotal	0	5,789	4,777	20,541	7,444	6,331	5,419	4,309	54,610
Global									
Country unallocated					800	700	600		2,100
Advocacy		118	70	280	355	357	348		1,528
Technical support		280	165	387	645	643	652		2,772
Bamako Initiative Management Unit	250	994	940	1,017	1,200	1,300	1,400		7,101
Subtotal	250	1,392	1,175	1,684	3,000	3,000	3,000	0	13,501
TOTAL	250	7,181	5,952	22,225	10,444	9,331	8,419	4,309	68,111

Source: UNICEF, New York.

Table 9

UNICEF INVESTMENT IN THE BAMAKO INITIATIVE:
BAMAKO INITIATIVE DEVELOPMENT FUND (UNFUNDED)

(In thousands of United States dollars)

Country	1989	1990	1991	1992	1993	1994	1995	Total
Benin	687	1,454	770	719	750			4,380
Burundi			3,745	3,280	3,010			10,035
Central African Republic								0
Cameroon				60	1,027	409	315	1,811
Congo								0
Equatorial Guinea								0
Ethiopia								0
Gambia								0
Ghana				234	675	721	547	2,177
Guinea			2,845	1,625	1,325	1,310	870	7,975
Guinea-Bissau								0
Kenya		255			1,085			1,340
Liberia								0
Madagascar								0
Mali								0
Mauritania								0
Niger								0
Nigeria			1,914	1,983	2,075	2,045	1,845	9,862
Peru								0
Rwanda			2,056	2,956	2,976	2,528		10,516
Sao Tome & Principe			50	50	50	50	50	250
Senegal								0
Sierra Leone		1,387	3,487	2,260	1,400	923	700	10,157
Sudan								0
Togo				890	1,158	994		3,042
United Republic of Tanzania								0
Viet Nam								0
Zaire								0
Zambia			440	514	376	338	305	1,973
TOTAL	687	3,096	15,307	14,571	15,907	9,318	4,632	63,518

Source: UNICEF, New York.

Table 10

EXPENDITURE ON ESSENTIAL DRUGS

(In United States dollars)

	1989 (6 countries)			1990 (12 countries)			1991 (18 countries)		
	UNICEF proc.	Reim. proc.	Total	UNICEF proc.	Reim. proc.	Total	UNICEF proc.	Reim. proc.	Total
Bamako initiative countries	1,779,132	320,486	1,912,701	1,765,923	402,033	2,167,956	2,240,976	1,071,087	3,312,063
Grand total (61 countries)	5,971,153	3,490,091	9,461,244	7,244,504	8,671,803	15,916,307	7,041,617	7,357,553	14,399,170

Proc. = procurement.
Reim. = reimbursable.

Source: UNICEF, Copenhagen (1989 figures exclude the United Republic of Tanzania and Mozambique).

71. Reimbursable procurement of drug inputs has risen from 17 per cent in 1989 to 32 per cent in 1991, indicating an increasing national capacity to cover drug costs and eventually a greater possibility of sustaining basic health services. Total UNICEF drug inputs for sub-Saharan Africa as a whole have averaged around $15 million for the last two years, with the reimbursable procurement proportion varying between 37 and 48 per cent. It is expected, however, that this pattern may change quite rapidly, especially when community reinvestment expands. Already in Kenya, for example, the demand not so much for drugs as mosquito nets impregnated with insecticide has begun and this will likely strain the ability of UNICEF to respond. Increasingly, UNICEF will have to support national procurement services, possibly in collaboration with the World Bank and other donors, rather than continue with direct imports, paid by UNICEF or on a reimbursable procurement basis, in order to build up sustainable national capacity for the long-term health commodity inputs for community health action. This would also serve to highlight the issue of foreign exchange usage, which, although recognized as a potential long-term constraint to the expansion of the Initiative, has not yet surfaced as a key problem in any specific core Bamako Initiative country. This is due mainly to the fact that, as yet, the Initiative has not generated amounts in local currency beyond the absorption capacity of UNICEF for reimbursable procurement.

IV. EVALUATION, MONITORING AND OPERATIONS RESEARCH

Evaluation

72. The United Kingdom/ODA-sponsored evaluation of the Bamako Initiative has been completed and is available for the 1992 Executive Board session. Central to this exercise has been the preparation of five case studies - Burundi, Guinea, Kenya and Nigeria, where the Initiative is being implemented, and Uganda, where a national health financing effort has been supported by UNICEF. The case studies, which have been carried out with collective financial support from ODA, the Danish International Development Agency, the Norwegian Agency for International Development, the Swedish International Development Agency, WHO and UNICEF, have enabled countries to assess and analyse key issues, leading to course corrections in the work being undertaken. Overall, recognizing the different ways the Initiative is adapted to different situations, one of the strongest aspects relates to the community development that is taking place, even though community health committees may not necessarily be fully representative of the community. The evaluation also highlights many of the systemic weaknesses present in public sector health services delivery, for example, in basic management, monitoring and supervision. The Initiative has generally been able to increase the utilization of services mainly because of the availability of drugs, although staff shortages and the poor salary conditions of health workers continue to act as a constraint to even greater impact. In general, the Initiative, where implemented, does not seem to pose great problems in affordability, although exemptions and credit issues are largely still unresolved. Finally, more attention will be required to reach a suitable balance between preventive and curative care.

Monitoring

73. UNICEF, through the Bamako Initiative Management Unit, has continued to support countries in the establishment of field-level monitoring systems. Both Benin and Guinea have operational systems, resulting in monthly reporting from health centres to district and central levels and twice-yearly assessment sessions to determine progress and constraints and to decide collectively on corrective measures. Nigeria has field-tested a monitoring system and an initial design has been completed in Ghana. This is a key area of UNICEF concentration in order to support the continuous assessment of action.

Operations research

74. Considerable effort has been made during 1991 to establish a more systematic work plan in operations research focusing on key issues surrounding the Bamako Initiative. Specific action initiated, under study or in preparation, include:

(a) "Cost of services, resources use and financing in the health sector" (Burundi, Zambia, Lesotho, Rwanda and Uganda), London School of Hygiene and Tropical Medicine (United Kingdom);

(b) "Rural health insurance" (Ghana), London School of Hygiene and Tropical Medicine (United Kingdom);

(c) "Quality of health care services" (Sierra Leone), Liverpool School of Tropical Medicine (United Kingdom);

(d) "Quality of essential drugs at point of use" (Bangladesh, Benin, Guinea, Mozambique, Myanmar, Peru, Uganda and the United Republic of Tanzania), Universities of Bradford (United Kingdom), Pavia (Italy) and Oslo (Norway);

(e) "Health communication and mobilization in the Bamako Initiative" (Cameroon), Tulane University School of Public Health (United States);

(f) "Financing of the Bamako Initiative" (Guinea), Centre International de l'Enfance (France);

(g) "Health financing of district health systems" (Mali), Institut National de Recherche en Santé Publique (Mali);

(h) "Support mechanisms in research for PHC strengthening focusing on financing and essential drug provision" (Rwanda), Université Laval, Faculté de Médecin (Canada);

(i) "Strengthening district health systems" (countries to be determined), Institute of Tropical Medicine (Belgium) and Royal Tropical Institute (Netherlands);

(j) "Community participation and equity in the Bamako Initiative" (Guinea), Université de Montreal, Faculté de Médecin (Canada).

75. The strategy followed by UNICEF is to support country-specific action on priority problems involving the appropriate local institutions along with those most directly concerned in the Ministry of Health. Technical support from academic institutions in other countries is used, when necessary, for the transfer of pertinent methodologies and research techniques within the framework of training local researchers and capacity-building in this area. Work in the fields mentioned, as well as others that will arise, will continue over the next three-year period in accordance with requests made by the Executive Board and as included in the programme recommendation that was approved by the 1991 Executive Board (E/ICEF/1991/P/L.30).

V. FUTURE AREAS OF CONCENTRATION

76. The Bamako Initiative is progressing steadily and coverage is expected to accelerate in the next one or two years as confidence in the strategy by both Governments and communities gains a strong hold and assuming that Governments, with the support of donor alliances, implement key policy changes. Several smaller countries, such as Burundi, the Congo, Mauritania and Sao Tome and Principe, are already envisaging national-scale action in revitalizing their health care delivery systems following the Bamako Initiative. Community demand could well drive rapid expansion in countries such as Kenya. Within this context, several key elements constitute areas of concentration in need of support, as set out below.

Development of leadership

77. The United Kingdom/ODA-sponsored evaluation has indicated that in some instances there is not full accord between national health policies and those of the Initiative. Leadership in-country will require greater support, especially in looking at issues affecting the development of policy as well as the implementation of specific activities. African countries implementing the Initiative will need to take decisive action on policy changes, notably in drug policies, provision of foreign exchange and increased decentralization, including the acceptance of community control.

Health information management

78. Better information management in countries that have already established effective monitoring systems has led to a greater appreciation of progress and constraints, leading to corrective action. Such work will need to be accelerated in other countries implementing the Initiative.

Health education and communication

79. Although the Initiative is creating an increased utilization of services, resulting in indirect educational benefits due to the active community

participation, educational opportunities are still being lost in the health provider/consumer contacts. More direct educational interventions will be undertaken given that it has been found that mothers, who are the main consumers of health care along with children, obtain most health knowledge from local health workers. Research work in Cameroon is specifically geared to establishing a methodology for analysing, introducing and testing educational interventions using all the communication media available in the country. This will not only be useful for other countries but will be a critical way in which the Bamako Initiative, in strengthening and extending basic health services, will support HIV/AIDS prevention strategies.

Alternative financing mechanisms

80. Community financing in the Bamako Initiative has been based mostly on the payment of treatment fees, which include essential drugs, or on payment linked more directly to the sale of drugs based on prescribed treatment norms. Interest has continued to be shown in other financing means, specifically prepayment mechanisms such as those used in Guinea-Bissau and Burundi. In the latter case, however, the current premium charged cannot cover local operating costs. Increasing it would undoubtedly lead to drop-out. Prepayment, none the less, can help to overcome problems such as the seasonality of cash, often most abundant at harvest time, and thus some of the indebtedness into which many families put themselves in order to pay for emergency medical care. The very poor, however, may be unwilling to contribute a premium until fully convinced of the benefits, thus stressing the need for a mixed system initially, i.e., prepayment for those who are willing and can afford the premium set at a rate commensurate with financing needs, together with treatment fees for those who are very poor or who do not yet see the benefits of prepayment. Generally, consumers appear to be unwilling to accept organized financing other than fees until they are confident that the quality of service is assured and that other mechanisms would result in lower costs to the household. A more systematic test of health insurance for rural areas will be conducted in Ghana in one district in the next two years, through the London School of Hygiene and Tropical Medicine and with the support of UNICEF and the International Development Research Centre. Over the long term, it is felt, however, that fees will evolve to prepayment and prepayment to insurance schemes.

Community reinvestment

81. Community investment in local health services is seen as the key to their sustainability. An established pattern of such investment has not yet clearly emerged. Communities in Benin are generating the equivalent of $1 million a year from the running of 200 centres ($5,000 on average per centre); in Guinea, the equivalent of about $600,000 per year is generated from the same number of centres ($3,000 per centre). Beyond the payment of small local costs (incentives, stationery, centre upkeep) large amounts are still being kept in interest-bearing accounts for the eventual purchase of essential drugs. More attention will be given in the next year to the use of community funds to create routine methods for investment.

National system for drug provision

82. The real capacity of central medical store distribution and logistics systems will be carefully reviewed in the next year in some of the main Bamako Initiative countries. Indications are, for example, that in Sierra Leone, which built the Initiative on the basis of a relatively well-functioning essential drugs programme, the supply system has slipped in the past year owing in part to the pressures of emergency distribution to people displaced by the war. Centralized public systems may not be the best or only solution, particularly considering their probable long-term inability to provide timely essential drugs and medical supplies to peripheral health services in accordance with community needs and commitments as a partner in financing and management. Often there is little motivation for staff to be effective or efficient; worse still, very low salaries can lead to corruption. In this regard, brand-name drugs are far more attractive than generics. Alternative means, including the non-governmental sector, will need to be explored. This cannot happen, however, without a greater commitment by countries to establish national drug policies and mechanisms to implement them. This whole area of work will be one of the principle tasks of the UNICEF Bamako Initiative Management Unit with the Drug Action Programme of WHO in the near future.

VI. PHASING

83. The exact future phasing of the Initiative, both in terms of expansion in the 18 core countries as well as its full adoption by other countries, remains promising. None the less, on a continent that is undergoing economic stagnation at the same time as rapid political change many factors will influence its actual expansion. During 1991, the Initiative was introduced into the national conference forum in the Congo; in Zambia, a new democratically elected Government is committed to addressing the deteriorating health situation with broad-based change. In these examples, the establishment of health policies in line with the Bamako Initiative took place much faster than originally envisioned. UNICEF will continue to put the Initiative at the front of its response to support the improvement of children's and mothers' health in sub-Saharan Africa, as well as in other developing countries that are embarking on major structural changes in the health sector.

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POLICY REVIEW

UNICEF HEALTH POLICIES AND STRATEGIES: SUSTAINABILITY, INTEGRATION AND NATIONAL CAPACITY-BUILDING

SUMMARY

Prepared in response to Executive Board decision 1991/11 (E/ICEF/1991/15), the present report addresses the issues of sustainability, integration and national capacity-building in UNICEF health policies and strategies. It reviews the evolution of UNICEF policy and practice, with special emphasis on immunization, the Bamako Initiative, programme integration and national capacity-building. It also discusses the conceptualization of these concerns with a view to further strengthening UNICEF programmes of cooperation. Based both on UNICEF experience and on evolving concepts, the report identifies the key aspects of and strategies for achieving sustainability. The annex contains an inventory of national capacities essential for sustainability of actions to improve health in developing countries.

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INTRODUCTION

1. Sustainability of systems and programmes has been a principal concern of UNICEF and the Executive Board for several years. In its decision 1991/11 (E/ICEF/1991/15), the Board considered that an important goal of UNICEF should be to assist Governments to develop sustainable, integrated national health care systems that meet the priority needs of their people, including but not limited to the needs of children. The Board stressed the need for the quantitative health sector goals adopted by the World Summit for Children to be adapted at the country level to national needs and circumstances and pursued through strategies integral to the development of sustainable health care systems. The Board also requested the Executive Director to report in 1992 on the extent to which UNICEF programmes support and strengthen national integrated health care systems.

2. In the light of the Board's request for a policy review, UNICEF used the opportunity to review its experience in health sector programmes, especially the issues of sustainability, integration and national capacity-building in the context of national health care systems. In preparing the present report, the secretariat held wide-ranging consultations with UNICEF development partners, including the World Bank, the World Health Organization (WHO), selected representatives of bilateral development assistance agencies and developing countries and knowledgeable specialists.

3. The present report reviews the conceptualization of sustainability, in addition to integration and national capacity-building for health programmes, based on UNICEF experience and with a view to further strengthening UNICEF programmes of cooperation through the incorporation of these elements. Sustainability is crucial because any programme that does not have a lasting impact on the people it is designed to reach is less likely to help meet long-term national development objectives.

I. THE 1980s: A DECADE OF DIRE NEEDS AND CHALLENGES

4. The economic decline of the 1980s had a negative impact on the developing world; average income fell by more than 10 per cent in Africa and Latin America and the already severe inequity of development in the world worsened. Although 50 of 78 developing countries experienced negative growth, only 2 of 28 industrialized nations did so. There was a net transfer of resources worth billions of dollars a year from developing countries to industrialized countries by the end of the decade.

5. The global recession, debt-servicing and structural adjustment programmes led to severe reductions in social expenditures in many developing countries, especially in the areas of health and education. The critical shortage of finances led to the rapid deterioration and collapse of social structures in many countries, especially in Africa. The proportion of public expenditure allocated to health fell to levels that were only one half of those of the

early 1970s. For example, in Uganda, public expenditure for health in 1988-1989 was only 16.9 per cent of the 1970 level, while the United Republic of Tanzania saw a drop of 30 per cent in health expenditures between 1980 and 1985.

6. In many of the poorest countries, particularly in Africa, health structures in rural areas ceased to function and were often abandoned owing to the lack of even the most basic drugs and operating funds and the non-payment or long-delayed payment of salaries. Even when they were paid, salaries were inadequate because of high inflation and erosion of the value of money. As a result, both preventive and curative services were affected.

7. The remaining public sector services were restricted for the most part to capital and major cities, except for missionary hospitals and clinics that continued to function in both urban and rural areas through the payment of fees by patients and external support. The provision of health care through private practice became common and was often carried out "after hours" in public facilities. However, because of the cost, it was restricted to the wealthier people who could afford such care or to those who were more seriously ill. The poor - the majority of the population - tended to resort more to traditional healers, drug peddlers and drug stores that often were not reliable or effective.

8. In the face of this deteriorating situation, various forms of external support were provided. Some donors continued to support the maintenance of city-based hospitals, mainly through capital investment, while a few channelled their support to peripheral areas through such elements as the construction of clinics, the provision of basic drugs, staff training and the development of management systems. Several non-governmental organizations (NGOs) also reoriented their support to the periphery with a district strengthening approach.

9. Very few donors were involved in promoting sector reforms, and health sector reform was thus influenced by structural adjustment. However, as the concept of "adjustment with a human face" gained acceptance, the World Bank increased its social sector lending, especially for health. In many instances, an overly economic approach to health sector development has led to distorted reforms, such as the indiscriminate application of cost-recovery mechanisms, without paying sufficient attention to ensuring adequate patient care and to increasing the overall efficiency of the health care system.

10. During the same period, UNICEF focused its attention on child survival and development (CSD), with the primary mission of saving children from unnecessary and preventable deaths and illnesses. The CSD "package" focused on growth monitoring, oral rehydration therapy (ORT), breast-feeding, immunization, food supplementation, family (birth) spacing and female education. However, immunization and ORT became more prominent for several reasons, including the possibility of setting quantifiable goals that were relatively easy to monitor, readily available technology, the relative ease of its implementation and its low cost. They were also the most effective direct

interventions for reducing child mortality because, as low-cost and affordable interventions, they promised a greater impact with a relatively small investment. WHO estimated that by 1990, 3.2 million lives had been saved each year through immunization and another 1 million lives through ORT and the control of diarrhoeal diseases.

11. The successful achievement of universal childhood immunization (UCI) led to the revitalization, strengthening and extension of health systems in many countries. Immunization services of some countries now reach more people than their postal systems. In Bangladesh, immunization services now reach 4,500 unions (a group of 6 to 20 villages), while formal health structures serve only 3,000 unions. The Government of Uganda has stated that immunization and essential drugs saved the public sector health care system during two decades of physical and economic disintegration. The most significant factor in the provision of immunization services in Uganda was not only the mobilization of resources, but also the fact that it gave a clear sense of purpose to local health workers. Essential drugs, where available, have provided the motivation for consumers to continue to use public sector services. In terms of infrastructure, the expansion of primary health care (PHC) units in Sierra Leone from 350 to 700 units has been attributed specifically to the extension of immunization services. In all countries, these immunization structures, whether fixed or mobile, have also led to improved work processes for local health workers through the clear definition of catchment areas and target populations, detailed planning, the organization of outreach systems, maintenance of the cold chain, information management, supervision and community mobilization.

II. EMERGING ISSUES AND RESPONSES

12. In view of the continued economic deterioration or slow economic recovery in developing countries, by the end of the 1980s, two critical issues had emerged:

(a) How to sustain the health services that had been established and the achievements made during the decade;

(b) How to revive and strengthen the public sector health care delivery system to meet a broader range of health needs.

13. In response, three significant initiatives emerged: sector reforms initiated by the World Bank; the strengthening of district health systems; and the Bamako Initiative.

A. World Bank sector reform

14. In 1987, the World Bank Policy Division identified the following three problems facing the health sector in developing countries: (a) insufficient allocation of public sector resources to the health sector; (b) inefficiency

of resource allocation within the health sector; and (c) inequity in the distribution of benefits from health services.

15. The Bank developed the following policy reforms in response: (a) charge fees to users of government facilities; (b) provide insurance cover or other risk cover; (c) use non-government resources effectively; and (d) decentralize government health services.

B. Strengthening of district health systems

16. In many countries, the paucity and lack of support from the central level resulted in the development of local initiatives to meet local health needs, with de facto decentralization of control. In several instances, this led to better local governance. Another positive outcome was the definition of the "district" as a management unit and the recognition of the need to strengthen support at the district level. The 1987 Harare Conference on District Strengthening, sponsored by WHO, was a milestone in the development of the concept. The key was to reduce the State's involvement in micro-management from the central level and put it squarely in the hands of local authorities with the means to implement action.

C. The Bamako Initiative

17. At a meeting of the WHO Regional Office for Africa in September 1987, building on the experience gained from interventions such as immunization and essential drugs programmes, African health ministers recognized the need to accelerate PHC and endorsed the concept of the Bamako Initiative. The Initiative is based on the principle of community participation in both financing and management of local health services, with decentralization of structures and authority and using the district as the main management unit. The purpose of the Initiative was to revive and strengthen collapsing health systems. Ensuring the supply of low-cost essential drugs would help to improve the quality of care provided and serve to attract community investment in health services.

III. SUSTAINABILITY: A UNICEF CHALLENGE

18. The three principal challenges to UNICEF in the 1990s are: (a) to help sustain the achievements of the 1980s, especially UCI and measures to reduce infant and child mortality; (b) to help improve and extend structures and systems that can ultimately sustain country achievements; and (c) to help build the capacity for priority activities initiated by countries to meet their goals and strategies for the 1990s. The following brief discussion of UCI and UCI Plus, the Bamako Initiative and UNICEF efforts to promote an integrated approach and national capacity-building reflects the experience and response of UNICEF to the three challenges.

A. Universal child immunization and UCI Plus

19. The UNICEF health agenda for the 1990s will work not only towards sustaining UCI, but also towards broadening it into UCI Plus in the context of establishing PHC as the basic pillar of the health care system. It will support the establishment and strengthening of health care systems, with a necessary focus on the greater integration of services based on maternal and child health (MCH) and women's health and within a broad-based approach of capacity-building and human resources development, in order to establish an adequate and sustainable response to health systems development. The major effort will be to extend and transform UCI structures into PHC structures, focusing essentially on the six big killers of children and women: vaccine-preventable diseases; diarrhoeal diseases; acute respiratory infections (ARI); malaria; human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS); and perinatal problems and women's health issues (encompassed under safe motherhood). These structures would benefit from coordinated action in the area of planning, supervision, training, support and information management.

20. In sustaining UCI, the principal recurrent costs are likely to be for vaccines and other local expenses. In better-off countries, local recurrent costs are increasingly funded through national or local financing. For example, in order to sustain continued immunization, communities in Kenya have expressed a willingness to use community-generated funds to help finance immunization sessions and to contribute to worker per diems and fuel costs in order that the frequency of immunization services can be maintained. Support for vaccine procurement is more difficult, however, because foreign exchange is required. The current UNICEF strategy for vaccine support has three elements: (a) support for local production in large countries with manufacturing capacity, especially through mobilizing the resources of the World Bank, regional development banks, etc.; (b) promotion of the Vaccine Independence Initiative, approved by the Executive Board in 1991 (E/ICEF/1991/P/L.41), under which vaccines are procured through UNICEF by Governments or national entities with foreign exchange or local currencies, which UNICEF, together with other development agencies, then uses for local purchases and expenses; and (c) continued provision of vaccines to countries not included in the first two categories.

21. Low-income countries will need continued support to meet the recurrent costs involved, most likely until the end of the century. The challenge to all donors will be to demonstrate the willingness to make long-term commitments until the end of the decade. At the country level, this would imply that donor assistance would be coordinated by the recipient Government and that the donor would accept this government coordination.

B. The Bamako Initiative

22. The Bamako Initiative is an approach to revitalizing, improving and extending sustainable health structures. As essential drugs are the main

component for improving quality of care, the Initiative promotes national drug policies based on the rational use of essential drugs.

23. In 1988, eight basic principles of the Bamako Initiative were elaborated:

(a) National commitment to accelerating the provision of universally accessible PHC services;

(b) Substantial decentralization to the district level of the health ministry's decision-making for the management of PHC;

(c) Decentralized management of community resources, allowing the funds collected at local facilities to remain under community control;

(d) The application of consistent principles for community financing of health care services throughout different levels of the health system, making it inappropriate to provide free services at urban hospitals while requiring payment for community-based services;

(e) Substantial government financial support for PHC to ensure that the health budget is maintained at least at its current level of support to district and local services;

(f) Essential drugs policies that are compatible with, and complementary to, the rational development of PHC;

(g) Measures for ensuring that the poorest people have access to PHC services;

(h) The clear definition of intermediate health systems and management objectives and the establishment of indicators to measure them.

24. The Bamako Initiative has evolved since its inception and is now being implemented in 33 countries. The latest developments of the Initiative are described in a separate report before the Executive Board (E/ICEF/1992/L.6). Although the Initiative's eight original principles have remained valid and have been promoted consistently, there have also been local variations in implementation, unique to each country and each community situation.

25. Also before the Executive Board is an executive summary of an evaluative review of the Initiative conducted by the London School of Hygiene and Tropical Medicine and based on case studies of Burundi, Guinea, Kenya, Nigeria and Uganda (E/ICEF/1992/L.20). The review, which was financed by the Governments of the United Kingdom, Denmark, Norway and Sweden, made 16 recommendations. The principal conclusion was that the following should be supported as an appropriate path towards the development of PHC: the strategy of revitalizing health services as defined by the features of community financing, community participation and national orientation; aims of improving quality and extending access; and strategic elements of management and accountability, together with the eight guiding principles of the Bamako

Initiative. The review also concluded that piecemeal and unbalanced approaches that omit some of these elements are inadequate.

26. The Bamako Initiative, which has been refined through experience since its endorsement by the Executive Board in 1988, is proving to be an effective approach for achieving sustainable health care systems that include both the curative and preventive aspects of health care.

C. Programme integration

27. While addressing the issue of support for the development of sustainable health structures, UNICEF has been coping with the issues of programme integration and national capacity-building. UNICEF programmes of cooperation have promoted integration both within and between sectors. While UCI and ORT have emerged as major components, country programmes also normally include other integrated CSD and MCH services in order to have a greater impact on the reduction of infant, child and maternal mortality.

28. The integration of programmes is also promoted across sectors. A typical CSD programme supported by UNICEF would thus be an integrated "package" with components for the principal child killers. The elements of such a package are most likely to be immunization for vaccine-preventable diseases; control programmes for diarrhoeal diseases, ARI, perinatal infections, malaria and AIDS; and supporting actions related to nutrition (including breast-feeding), water supply and sanitation, basic education, the role and status of women, communications, social mobilization and other interventions relevant to the national context.

29. UNICEF experience suggests that integration is most effective at the operational level and in situations where the national administrative structure is decentralized. The involvement of subnational-level administrations is essential to the process. At the central level, national bureaucracies are organized sectorally and vertically, and multisectoral coordination is best accomplished through national coordination mechanisms such as the offices of the President or Prime Minister, or the national planning commission or the governor's offices at the provincial level.

D. National capacity-building

30. In view of the importance of the availability of trained human resources, training has been a significant element of UNICEF programmes of cooperation since the mid-1970s, when the programme approach was adopted. An average 6 to 7 per cent of total programme expenditure was spent on training during each of the last five years, with $40 million spent per year in 1990 and 1991. UNICEF-supported training generally takes place at the operational level. Experience has shown that unless training is accompanied by close supervision and support, its impact may be limited and hard to sustain.

31. In the 1980s, the approach to human resources development in programmes was broadened to include more involvement and use of national institutions, universities and learned institutions and to use programme locations as training sites for university teaching. The disadvantaged counties project in China and the national capacity-building projects in Kenya and Uganda are some of the unique examples that close the gap between academia and development programming.

32. China's disadvantaged counties projects serves 300 underdeveloped counties. Health and nutrition activities are supported by medical universities and referral hospitals in research, training and evaluation, so that the projects developed reflect the epidemiological needs of each county and also receive support at each critical stage. University teaching is in turn enriched by involvement in actual field conditions.

33. The national capacity-building project in Uganda is also based on the premise of building linkages between universities, government health care institutions, health providers and communities. The project has established training and practice areas where future doctors and other health personnel learn by dealing with actual problems and tailor their research and teaching accordingly. The practice areas also benefit from the attention of these experts.

34. The experience of the Bamako Initiative has indicated that national capacity-building should also include local government and community levels, especially for strengthening management skills and for the experience required for better local governance, which can lead to better prospects for sustainable action. Especially at the community level, it has been found that the "triple-A" approach (assessment, analysis and action) to community capacity-building (especially in Iringa, United Republic of Tanzania, which is the most widely known example) can overcome a community's "fatigue" with development projects because there is local ownership and accountability, with a broad base of informed health care users.

35. An underrated aspect of national capacity-building appears to be technical cooperation among developing countries (TCDC) and within countries. TCDC provides not only a means of learning, but also a sense of competition between colleagues who try to outperform each other through improvements and innovations.

36. Some of the lessons learned from past experience about national capacity-building can be summarized as follows:

(a) National capacity-building needs to include both human resources development and institutional development;

(b) The development of human resources and institutions must include the strengthening of operational capacity and the means to provide adequate operational financing;

(c) Full involvement and operational partnerships are effective, but actual problem-solving appears to be the most effective form of training;

(d) Permanent dialogue and working relationships between professionals at different levels and in different institutional settings are more effective than sporadic missions;

(e) The retention of trained personnel remains a challenge because of increased social mobility, in addition to losses caused by out-migration and employment by donor agencies and private and external NGOs that offer more lucrative remuneration.

37. All human resources development and capacity-building activities must be viewed in the context of an emerging crisis in many countries because poorly trained and paid workers, who increasingly lack appropriate tools, are providing fewer quality services to the population.

IV. THE MAIN DIMENSIONS OF SUSTAINABILITY

38. Although sustainability has been associated primarily with financing, it has evolved into a broader concept. In many countries, sustaining health services is not simply a question of financing projects, but also one of the actual capacity to run the system. Many institutions have now come to view sustainability as the capacity of the health system to function effectively over time with a minimum of external input, although many doubt that this approach is realistic in view of the situation and pressing needs of low-income countries, especially in Africa. The experience of UNICEF suggests that a definition proposed by the International Development Management Center, University of Maryland (United States), based on its exploration of sustainability in several development sectors, is the most appropriate. According to that definition, sustainability is the ability of a system to produce benefits valued sufficiently by users and other stakeholders (actors other than users with an interest in what the system does) to ensure enough resources to continue activities with long-term benefits. The definition highlights sensitivity to client demand as well as the value assigned to output by various groups, including Governments, communities, donors and users.

39. It is now generally accepted that sustainability has five distinct yet interrelated key aspects: political; financial; managerial; technical; and cultural.

A. Political sustainability

40. Political commitment is the sine qua non of any successful, sustainable effort. It generates appropriate national policies, legislation and structural changes; supportive national and subnational budgets; and popular and social mobilization. Achieving political commitment is easier when there are feasible and realistic solutions to problems that have been identified as national priorities. National commitment to PHC can be translated into:

(a) The establishment of national policies and appropriate legislation, providing a legal framework;

(b) More balanced and equitable government budgets and staff allocations to PHC among both rural and urban communities;

(c) The restructuring of systems towards more decentralized management and local autonomy;

(d) The adoption of appropriate health and management technologies;

(e) Popular participation, with broader roles for community financing and management;

(f) Recognition of the role of NGOs and the private sector as partners;

(g) The involvement of the leaders of different sectors of society in PHC, including teachers, traditional and religious leaders and the media;

(h) Willingness to coordinate external support based on national PHC policies.

B. Financial sustainability

41. Financial sustainability is also crucial. Although a society cannot abdicate its responsibility to provide basic services to its population, current levels of government spending are insufficient to finance health needs fully, as indicated in a World Bank study on financing health services in developing countries. Because government budgets and services are unreliable and inadequate in many countries, partnerships have been organized with communities for the provision of basic health services. The Bamako Initiative is a good example of such a partnership, with decentralized structures providing better quality services under community management, financed by the community with support from central and local governments. Donor support is critical at the beginning of the partnership in order to improve the quality of care enough to attract community investment.

42. Because countries are at different stages of economic development, their health systems need different approaches. However, most countries could benefit from incorporating some or all of the following elements in their policy reform, thus contributing to the sustainability of health services:

(a) Establishing a system of community cost-sharing and management of health facilities and services, with measures to protect the poor;

(b) Encouraging the non-governmental sector (within an overall framework of national health care) to provide health services for users who are willing/able to pay;

(c) Decentralizing government health service operations, including planning, budgeting, decision-making and revenue retention at the local level. The central Government would focus more on national policy and management issues, such as the definition of service standards and technical norms at each level, a financing policy, development of monitoring and support arrangements, an essential drugs policy, the quality control and safety of pharmaceuticals, human resources development, research and vaccine procurement;

(d) Providing insurance or other risk coverage on a broad basis. A modest level of cost-recovery is possible without insurance, but in the long run, some form of insurance will be necessary for large segments of the population in order to relieve the government budget of the high costs of curative care.

43. A major focus in the area of financial sustainability should be on developing affordable systems with different means of support and built-in safety nets for the poor. The types of safety nets should be determined in accordance with the cultural milieu of each community. In many cultures, it is inappropriate to label a person publicly as "poor" and communities prefer that less-endowed members be supported through networks of extended families and kinship. Recent research from Cameroon has indicated that systems improved as part of the Bamako Initiative are actually used more by the poorest 20 per cent of the population because it is the only affordable option for them. However, this does not obviate the need to protect the real indigents.

44. A continuing challenge in the 1990s is likely to be the need for support for recurrent costs from donors. Because it is unlikely that many low-income countries will be able to absorb immediately all the recurrent costs incurred in the implementation of revitalized systems, an abrupt cessation of support for those costs could lead to the collapse of the systems. The best sustainable approach is likely to be one of long-term donor support on a sliding scale and the simultaneous development of domestic support systems.

C. Managerial sustainability

45. Managerial sustainability is imperative in order to maintain efficiency and adequate system performance levels. UNICEF experience has shown that management by objectives not only contributes to the achievement of established goals, but also produces a system of accountability, enhancing managerial sustainability. Good management systems (based on the setting of clear objectives and targets, action planning, budgeting, supply and logistics systems, human resources placement, training, supervision and information and monitoring systems) will ensure that the quality and effectiveness of services are established and maintained. Some key management factors that contribute to the efficiency and sustainability of health systems include:

(a) Decentralization of services accompanied by the decentralization of authority and institutional autonomy - creating community ownership - and establishment of accountability at different levels;

(b) Managerial leadership and availability of basic management skills (e.g. cost accounting) in the public and private sectors;

(c) Involvement of communities (especially women) in decision-making and in revenue-raising and retention;

(d) Role of the Government in policy-making, regulation and monitoring as opposed to providing services;

(e) Management information systems that encourage the use of information in decision-making at all levels, in addition to local research capacity, to make informed decisions.

D. Technical sustainability

46. If the systems and services sustained are to be effective, standards and performance indicators need to be established and applied. Technical sustainability is closely linked to the technology chosen for the systems. Many projects break down despite the existence of more appropriate alternatives because they rely on technology that is either too sophisticated for the existing infrastructure or too expensive to maintain. Non-medical technologies such as transportation are often as important as medical technologies as they also affect the functioning of the health system.

47. The choice of technology should be based on operations research and the potential for the local or regional provision or production of necessary supplies, equipment, spare parts and consumable goods. Some technical choices can also serve to reinforce sustainability: a disease surveillance system can be a foundation for future programmes; birth spacing has positive effects on long-term maternal health and infant mortality reduction; and a mass communications strategy can help to create demand for service delivery.

E. Cultural sustainability

48. Cultural values have a strong effect on all systems and initiatives that run counter to these values are harder to sustain. Local cultural and social values must be studied, understood and reflected in programme approaches and strategies. However, respect for cultural values should not ignore or reinforce negative cultural practices that threaten the life and well-being of people, especially women and girls.

49. In this context, the development of sustainability of health structures and systems can be seen as a process that requires learning from examples, experience and evaluation; is based on a partnership between the Government, communities and donors; takes into account the views and perceptions of both users and providers; looks beyond health sectors at broader societal factors; and is enhanced by enlightened demand creation through the empowerment of people.

V. STRATEGIES FOR ACHIEVING SUSTAINABILITY

A. Sector development

50. Within the framework of sector development, sustainability needs to be viewed in a broad context since it is the strength of the sector that will be under test. Sustainable development requires structures and systems that are capable of functioning effectively over time, taking into account political, financial, managerial, technical and cultural factors.

51. Sector development will also need to involve more efficient use of established infrastructures and services. There are increasing financial and resource constraints to the further development and expansion of facilities and services, including the need to cope with new diseases. For example, the impact of HIV/AIDS may need to be examined because of its potentially negative effect on sustainability through a disproportionate use of resources on AIDS patients. Issues related to equity must be addressed in order to reach underserved segments of the population, while priorities must be determined and interventions applied selectively in view of limited resources.

52. In the context of system building, it is crucial to recognize the role of socially active institutions, because without such institutions, which can plan and direct action, longer-term sustainability can be jeopardized.

B. Systems and structures with a purpose

53. Systems and structures are more effective, efficient and ultimately more sustainable when they have a purpose. Based on specific goals and targets, a purpose provides a specific context in which to work, encourages ownership and accountability and instils the practice of management by objectives. The systems and structures need to be supported by effective management information to facilitate sound decision-making and better governance.

54. Priority problems for the system should be defined by the people most closely associated and concerned with it, in the spirit of decentralization, while taking into account the countervailing forces that bear on decision-making. Overall national goals and targets would be most appropriately set at the national level, stimulated by global initiatives that may have the benefit of cross-country experience and knowledge and are based on well-accepted ethical considerations. National goal-setting also provides the possibility for mediation of the potential conflicts of community-induced goals. In this context, mortality reduction goals would necessarily relate to all the health system issues that need to be addressed as well as promote the possibility of profound change of perception in the community about health priorities and actions.

C. National capacity-building and strengthening of institutions

55. Creating sufficient capacity at the national level, in terms of deployment of human resources and institutional development, is crucial for sustainability. Such capacity-building should build on what already exists, taking into account community priorities in health. It is important to build national capacity using the ability to prioritize and make health development decisions based on accessible and reliable information. Conflict resolution, often involving local and national decisions, would be an important part of this work.

56. While better trained, located, supervised and remunerated human resources would be a principal purpose of national capacity-building, because the human factor is perhaps the most critical element of sustainability, it is also important that an enabling organizational setting be established for people and organizations to function effectively. Attention should also be paid to institution-building and strengthening so that institutions can provide continuity and improved effectiveness in building national capacity. An inventory of essential national capacities that would contribute to determining the sustainability of actions for improving health in developing countries is provided in the annex to the present report.

57. A key issue in institution-building is the dual role of health ministries as guardians of national health, both as public advocates and educators for better health and healthy living, and as guarantors of accessible health care for the sick and the disadvantaged through direct provision of services or appropriate subventions. The balance between the two roles and the way they are undertaken will determine a ministry's effectiveness in combating the nation's problems and cost-effectiveness in public sector health actions. It should be recognized that the public sector may not be very cost effective in the area of health if its main role is to provide services for the poorest and disadvantaged, whose care is often more expensive and who are often unable to contribute significant resources to health. Related to this changing matrix is the need to acknowledge the place of the private and non-governmental sectors as providers of health care.

D. Demand creation

58. Experience suggests that sustained demand stimulates sustained response. Demand creation is often described as a precondition for sustainable actions. It is important that priority action at national levels take into account, and balance with, other priorities at subnational and local levels so that an appropriate balance is maintained in each locale in demand creation efforts. Sustainability is normally a dynamic process that depends on the balancing of different countervailing forces, demands and viewpoints.

E. Health and health services

59. In considering sustainability, it is important to remember that health is broader than the mere delivery of health services. At present, ministries of health must play dual roles: as providers of health services with service outputs; and as public advocates and educators for better health and healthy living. The second role is equally, if not more important, given increasing restraints on health resources. Irrespective of the advocacy/service "mix", health ministries must increasingly act as "orchestrators", a strategic function, rather than solely as guardians of public health. Donors, on the other hand, can be advocates for better health, but each country must decide its own direction for restructuring and action. More donor sensitivity in this regard is needed, particularly as their collective financial influence tends to overwhelm Governments in low-income countries.

F. Integration at the operational level

60. For systems to be effective, their elements need to be integrated at the operational level, which is cost-effective, synergistic in outcome and more efficient. As financial resources are likely to be scarce during the 1990s, even with a commitment to greater efficiency, there will not be sufficient resources for all desirable health actions. Communities will likely be obliged to select actions, and be more likely to invest in the aspects of care they viewed as most critical, while bearing in mind that 80 per cent of system users are children and women.

VI. CONCLUSIONS: PREREQUISITES OF SUCCESS

61. In the context of national capacity-building and institution strengthening leading to the sustainability of systems and structures, some of the prerequisites for success would include:

(a) Advocacy for "health as investment", taking into account the prevailing forces that are concerned with health in a country;

(b) Decentralization of administrative structures and strengthening of community structures;

(c) Mobilization of resources, including cash;

(d) Establishing and strengthening systems that deliver specific outcomes;

(e) Streamlining processes that enable the introduction of delivery systems;

(f) Strengthening and supporting institutions ready to bring about these processes of change.

62. Those six points of action represent the UNICEF agenda for supporting sustainable health action for incorporation into country programmes of cooperation.

63. Within this framework, desirable system changes would include: (a) establishment of clearer standards for the effectiveness and coverage of health care services; (b) setting performance indicators for cost-effectiveness; (c) the introduction of financial controls; (d) greater responsiveness to health workers' needs; (e) increased focus on the performance of personnel; (f) systems that deal with and support infrastructure maintenance; (g) sensitivity to users' needs and demands; and (h) the incorporation of community organization.

64. Sustainability is complex and not without certain potential contradictions. The need for organizational decentralization should be viewed against the need to maintain services of a reasonable quality. Similarly, the need to attain financial efficiency in a resource scarce environment should be weighed against the desire to pursue equitable development, particularly for the poorest, who are least likely to be able to contribute to the costs of health care. These are some of the longer-term structural and ethical issues that still need to be addressed more comprehensively. There is clearly a need for collective thinking by all concerned because policies and actions necessary for building sustainable systems are likely to have political costs that cannot be ignored. Therefore, appropriate incentives will have to be found so that a broad alliance can be established to facilitate change.

Annex

SUSTAINABILITY OF ACTIONS TO IMPROVE HEALTH IN DEVELOPING COUNTRIES: AN INVENTORY OF ESSENTIAL NATIONAL CAPACITIES

In any situation, there will be a need to prioritize and select capacities that need development.

I. Conceptual, policy-making and planning capacities

A. Analysis

1. Analyse the health status of different groups in society;

2. Identify causes of ill-health;

3. Assess perceptions of ill-health;

4. Quantify health-seeking behaviours;

5. Examine access to services (public/private, traditional/modern);

6. Community management and communication systems (need for policy makers and planners to be able to commission analyses and for researchers to deliver useful products in response).

B. Priority setting

1. Prioritize health problems at different levels (community/district/national);

2. Seek legitimization of priorities in different (participatory) forums;

3. Establish again at different levels and legitimize goals and strategies to tackle priorities;

4. Select and incorporate in strategies, cost-effective interventions and delivery systems;

5. Seek and obtain finance from a mixture of public and private sources. (Need for a variety of groups both within and outside government to establish this capacity.)

C. Communication

1. Communicate policies, goals and strategies to all interested parties, promoting participation where possible;

2. Establish mechanisms for regular review by legitimizing forums as identified above.

II. Service provision capacities

Agencies that are mandated or contracted to provide services should be able to:

1. Set standards for services provision, according to agreed policies, goals and strategies;

2. Devise efficient methods for ensuring that people receive services according to the agreed standard, through public and/or private providers;

3. Secure finance for, deliver and monitor services, with regular assessments of quality, effectiveness and cost;

4. Ensure equity of service provision, so that disadvantaged people have the services they need, when they need them.

III. Management capacities

Agencies mandated or contracted to provide services must be able to:

1. Devise procedures to deal with demands of varying complexity, establishing referral networks (and standards for referral);

2. Establish systems for supply (procurement and distribution), transportation, information collection and analysis, etc.;

3. Establish systems for investigating instances where standards are not being maintained and for introducing corrective action;

4. Establish systems to safeguard the interests of all personnel - including professionals - and to ensure that no one group has a disproportionate influence on priorities or activities;

5. Establish systems for delegating control over service provision to the local level, wherever possible.

IV. Institutional capacities

A. In-country institutional capacity is needed to:

1. Monitor policy development and implementation through research and dialogue;

2. Establish training needs and ensure that service providers, researchers and policy makers at all levels receive the training they require;

3. Monitor and evaluate system/service delivery performance;

4. Relate to donors, industry and other parties who have an interest in national health issues, ensuring that these external bodies are not able to distort local or national priorities, goals or strategies.

B. A number of external contextual factors will influence whether or not these in-country capacities will facilitate sustainable health development. These include:

1. Public sector regulations and procedures: the progress of public sector reforms;

2. Budgeting, auditing and accounting processes in the public sector;

3. National policies for decentralization or centralization, and their implementation;

4. National policies for deregulation, privatization and/or contracting out, and their implementation;

5. National, regional and local mechanisms for generating, and responding to, public pressures, advocacy and lobbies;

6. Donor coordination mechanisms.

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